Supreme Court, U. S.
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IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1691

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of St. Joseph's Hospital, METHODIST HOSPITAL, and DELAWARE VALLEY HOSPITAL COUNCIL, on Behalf of Themselves and All Others Similarly Situated,

Appellants,

v

F. EMMET FITZPATRICK, District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in Their Official Capacities, THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA, and BLUE CROSS OF GREATER PHILADELPHIA,

Appellees.

JURISDICTIONAL STATEMENT.

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No.

PAUL I. GUEST, et al.

Appellants,

v.

F. EMMET FITZPATRICK, et al.

Appellees.

JURISDICTIONAL STATEMENT.

Appellants ask this Court to note jurisdiction to review the opinion and order of the three judge court entered in the above case on March 2, 1976.

CITATION TO OPINION BELOW.

The opinion and order of the lower court is not yet officially reported, but is appended hereto at pp. A5 to A33.

STATEMENT OF JURISDICTION.

Direct appeal to this Court is taken from the opinion and order of a three judge federal district court denying appellants' request upon summary judgment motion for a permanent injunction and granting appellees' cross-motion for summary judgment in an action pursuant to 28 U. S. C. §§ 2201 and 2202. Appellants were seeking to have declared unconstitutional and to have preliminarily and permanently enjoined the enforcement of the Pennsylvania Act of August 2, 1975, Act No. 94, 40 Pa. C. S. § 6124(c), a complete copy of which is attached hereto at pp. A1 to

A4. The district court entered its opinion and order on March 2, 1976,[1] and notice of this appeal, a copy of which is attached at p. A34, as well as of a protective appeal to the United States Court of Appeals for the Third Circuit, was filed in the United States District Court for the Eastern District of Pennsylvania on March 22, 1976.

This Court has jurisdiction pursuant to 28 U. S. C. § 1253 in that this appeal is taken from a final order denying permanent injunctive relief in a civil action required to be tried by a district court of three judges. **Florida Lime & Avocado Growers, Inc. v. Jacobsen,** 362 U. S. 73 (1960).

STATEMENT OF QUESTIONS PRESENTED.

1. Do not the Due Process and Contract Clauses prohibit retroactive state legislation which effects an impairment of substantive contract rights and a taking of property without just compensation, even though the state purports to have so legislated in accordance with its view of the public welfare?

2. Assuming arguendo that legislation retroactively extending and reinstating private contracts may be given the legal effect of prospective rate regulation, does not the Constitution protect a private, non-profit hospital from being compelled to render service at rates which do not permit it to recover its full historic costs of doing business?

3. Absent any state hearing procedure through which the hospitals could protest their being obliged to provide service at non-compensatory rates, was not the district court at least obliged to provide the hospitals a hearing on their allegation that the rates under which Act 94 compels them to provide service are confiscatory?

1. Although the order is dated February 27, 1976, it was not entered until March 2, 1976. The earlier date is used in the notice of appeal to avoid any question with respect to its timeliness.

STATEMENT OF THE CASE.

Procedural History.

This is an appeal from the decision of a three judge court upholding the constitutionality of the Pennsylvania Act of August 2, 1975, Act No. 94. That Act, which amends Section 6124 of Title 40 of the Pennsylvania Consolidated Statutes, provides that no contract between a hospital plan corporation, such as defendant Blue Cross of Greater Philadelphia ("Blue Cross"), and an eligible hospital may be terminated except upon ninety days notice and subject to prior approval by the Insurance Department of the Commonwealth of Pennsylvania. When the hospital or hospitals involved have more than five percent of the beds in an area served by a hospital plan corporation, as do appellants here, the Insurance Department is authorized to suspend further the termination of such contract for a period of ten additional months, during which time the contract sought to be terminated is to continue in full force and effect while the Insurance Department holds hearings and may supervise contract negotiations.

It is explicitly provided that the Act shall apply retroactively to the termination of any covered contract "under which subscribers [of the hospital plan corporation] received prepaid benefits on or after June 30, 1974 . . . [which] contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of the Act." Section 2(2), 40 Pa. C. S. § 6124(c)(2).

The Act provides at Section 1(c)(5) that if a new contract is successfully negotiated during the statutory extension period "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties."

There is no provision for any adjustment of payment made under the contract during the thirteen month statutory period of suspended termination if a new agreement is not negotiated.

On September 12, 1975, an Amended Complaint[2] was filed on behalf of a class comprised of all hospitals which were or are parties to contracts covered by Act 94 and all executive officers, administrators and employees of those hospitals who would be exposed to criminal prosecution under Section 6105 of Title 40 for violations of the Act, seeking to have Act 94 declared unconstitutional and its enforcement against plaintiffs preliminarily and permanently enjoined. The case was assigned to a there judge panel in accordance with 28 U. S. C. §§ 2281 and 2284, and was heard by agreement of the parties upon oral argument on October 14, 1975, on cross-motions for summary judgment and supporting affidavits of fact and memoranda of law.

On March 2, 1976, a final opinion and order of the court was entered by District Judge Charles R. Weiner, joined by Circuit Judge Francis L. Van Dusen, denying appellants' motion for summary judgment and granting appellees' motion for summary judgment upon the request for permanent injunctive relief (see District Court Opinion at A6, n. 1). District Judge Alfred L. Luongo dissenting, would have held Act 94 unconstitutional [illegible] "retrospective effect" or at the least would have required that there be a trial of the disputed issues of fact. Dissenting Opinion at A26, A29, n. 1. Appellant filed notice of this appeal and a protective appeal to the United States Court of Appeals for the Third Circuit on March 22, 1976.[3]

2. The original complaint was filed on August 11, 1975, but was amended in accordance with a subsequent stipulation of the parties.

3. A separate notice of appeal to this Court was filed March 24, 1976, by counsel for Williamsport Hospital and the Hospital Association of Pennsylvania, plaintiffs-intervenors below.

Operative Facts.

Defendant Blue Cross is a hospital plan corporation within the meaning of the relevant statute, 40 Pa. C. S. §§ 6101 *et seq.*, having received a Certificate of Authority under Section 6102 to establish, maintain and operate "[a] plan whereby for prepayment, periodical or lump sum payment hospitalization or related health benefits may be provided to subscribers to such plan." 40 Pa. C. S. § 6101.

Of course, Blue Cross does not itself provide "hospitalization or related health benefits." Rather, it is authorized to contract with hospitals which provide such services to Blue Cross subscribers to accept reimbursement directly from Blue Cross in accordance with a negotiated payment schedule. Any hospital incorporated under the laws of Pennsylvania may enter such a contract with Blue Cross, 40 Pa. C. S. § 6121, thereby becoming a so-called "member" hospital. On the other hand, many hospitals have chosen in the past not to become members of a hospital plan corporation.

However, at least until the passage of Act 94, no hospital could be required to negotiate a contract with a hospital plan corporation or otherwise to accept payment from a third party payor of less than its normal charges. Therefore, when a Blue Cross subscriber receives services from a "non-member" hospital, the hospital retains its common law right to collect payment from the subscriber-patient who, in turn, can collect from Blue Cross, but only to the extent of the non-member benefits available under the terms of the subscriber contract.

The public emergency claimed by the legislature and the court below to justify passage of Act 94 was the termination, more than a year before passage of the Act, of a contract negotiated by defendant Blue Cross and

plaintiff-intervenor Delaware Valley Hospital Counsel ("DVHC"), and the consequent loss of "member" status by the 37 hospitals represented in contract negotiations by DVHC (the "Delaware Valley Hospitals").[4] In fact, the contract, which was entered into on July 1, 1971, and was terminable upon 90 days notice, should have expired by its terms on July 1, 1972; however, it was continued by a series of interim agreements until March 31, 1974, when, after more than two years of unsuccessful efforts, further negotiation seemed futile.[5]

4. Pertinent portions of this contract as well as the various addenda which together were referred to below as the "Delaware Valley Agreement," are attached as Exhibit B to the Memorandum of Plaintiffs and Plaintiffs-Intervenors in Support of Motion for Summary Judgment.

5. The two year contract provided for a ceiling limitation (over the prior year's costs) on Blue Cross payments for the first contract year only; it provided further that unless new payment terms could be negotiated six months prior to the end of the first year, the contract would terminate as of July 1, 1972. However, on July 1, 1972, when federal price controls were in effect under the Economic Stabilization Act, the parties agreed that the contract would continue and the hospitals would be reimbursed their allowable costs as approved by Blue Cross for the prior year plus only that increase permitted by the applicable federal control ceilings. (This is the so-called 1972 Amendment.)

The parties still had not been able to negotiate a new contract when the Hospital Agreement, as amended, terminated on July 1, 1973. They continued to negotiate, however, and in February, 1974, agreed to a "Summary of Principles" retroactive to the July 1 termination date as the basis for an ongoing contractual relationship. The Summary of Principles basically continued in effect with some minor modifications until March 31, 1974, the previous Hospital Agreement as modified by the Amendment of July 1, 1972. Thus, through March 31, 1974, Blue Cross continued to reimburse plaintiff Delaware Valley Hospitals in accordance with the ceilings imposed by federal economic controls.

When the parties failed to reach agreement on a new contract by March 31, 1974, the Agreement, as modified and extended by the Summary of Principles, terminated and a ninety-one day "continuation" period commenced. By agreement this "continuation" period was extended for an additional 31 days until July 31, 1974. Finally, on August 1, 1974, the hospitals rejected Blue Cross' attempt to extend the agreement unilaterally to August 15, 1974.

The simplest explanation for the failure of the contract negotiations is that Blue Cross payments under the Delaware Valley Agreement simply did not cover the hospitals' true allocated costs of providing service to Blue Cross subscribers. Rather the Agreement was based on a principle under which the hospitals were reimbursed the identifiable cost of services rendered individual Blue Cross subscribers, but no part of the expenses incurred by the hospitals in providing care to indigents, in writing off uncollectable amounts other than those of Blue Cross subscribers during the period of their coverage, in providing charity allowances, in undertaking certain educational and research activities, and in providing for future growth needs.

These items of hospital expense excluded from the Blue Cross reimbursement formula are not identified to any individual patient, but are part of the hospitals' total cost of providing service. Normally, they are billed accordingly on a pro-rata basis to all private paying patients. Thus, Blue Cross' refusal to recognize these costs results in a loss to the hospital of the difference between the amount of charges properly allocable to Blue Cross subscriber-patients and the amount of reimbursement actually paid by Blue Cross.

As developed in appellants' affidavits, there was no hospital which did not suffer such a loss under the Delaware Valley Agreement, though the amount of loss varied from a low of $50,000 per year in the case of Jeanes Hospital through $203,400 reported by Presbyterian-University of Pennsylvania Medical Center to more than $655,000 reported by Mercy Catholic Medical Center for fiscal year 1974. See Affidavit of Edward J. Armstrong, paragraph 10, and Supplemental Affidavit of Joseph A. Williamson, paragraph 6.

For non-profit hospitals, such as appellants, the amount of these Blue Cross underpayments necessarily translates into a net operating loss.[6]

In order to make up for the deficiencies in the Blue Cross cost reimbursement formula, the Delaware Valley Hospitals had insisted that any new contract must include some additional payment which would permit the hospitals to recover their operating costs. Such a so-called "plus factor" is common in Blue Cross contracts and, in fact, had been included in a prior agreement between Blue Cross and DVHC dated July 1, 1967. Ultimately the Insurance Department, itself, recommended the inclusion of a plus

6. As is documented in the affidavits relied on by appellants below, there are only a limited number of sources from which a non-profit hospital may recover the operating expenses which Blue Cross refuses to pay. Some is surcharged to those private patients who are self-insured or covered by commercial insurers. While in most cases it is not possible to impose the entire burden on this relatively small segment of the patient population, the need to reduce losses by surcharging private paying patients has resulted in situations where private insurers may pay full charges as much as 40% more than those paid by Blue Cross for comparable services rendered its subscribers. Williamson Affidavit, paragraph 7.

To the extent that the pool of private paying patients is too small to make up the total deficiencies in Blue Cross payments (and, as the burden of these deficiencies on the private paying patients becomes greater, more members of this group who are able to do so are under pressure to become Blue Cross subscribers, thus, shrinking the size of the pool and increasing accordingly the burden on each member in a self-accelerating process), the hospitals must reduce their net operating loss from non-operating income sources. Thus, they use unrestricted endowment fund income where available and, in at least one case, endowment fund principal to the extent permitted by law. Williamson Affidavit, paragraphs 8 and 9. The most common device, however, is for the hospitals to meet their current operating needs by utilizing that portion of Blue Cross payments which is supposed to be funded for a depreciation reserve. In some cases, it is necessary for a hospital to use up virtually all of its depreciation reserve to meet its daily operating needs. In this way, the hospital remains solvent by pushing forward its bottom line operating loss to some future time when it will be unable to replace fully depreciated facilities and equipment. Williamson Affidavit, paragraph 10.

factor as a basis for negotiations between Blue Cross and DVHC; however, while negotiations proceeded for a time on the assumption that a plus factor would be included, Blue Cross finally refused to offer DVHC anything beyond the direct cost reimbursement formula. Affidavit of Paul I. Guest, paragraphs 2-5.[7]

When the extended 1971-72 agreement between Blue Cross and the hospitals expired, the hospitals did not have or assert a right to collect full charges from Blue Cross subscribers immediately upon termination of the Delaware Valley Agreement. Rather, on August 15, 1974, the contractual 12 month run-out period commenced with the effect that following termination of the hospital agreement as a general contract, it continued in force on an individual basis for the term of any subscriber contracts entered while it was in general effect.[8]

7. As a matter of fact, within a few days following passage of Act 94 the DVHC negotiators and the attorney for Blue Cross, through the efforts of and in the presence of Mr. Mongelli, Deputy Insurance Commissioner, reached complete agreement on a package settlement which was acceptable to the Insurance Department and the negotiators. The hospitals accepted the proposed contract; however, the Blue Cross Board of Directors rejected it. That contract, approved by the defendant Insurance Department, included a plus factor of 4% per year for each of three years. See Guest Affidavit, paragraphs 7-10; See also Williamson Affidavit, paragraph 15.

8. The Delaware Valley Hospital Agreement provides as follows at Section 27:

Obligations after Termination

"In the event this Agreement terminates for any of the reasons set forth herein, the Provider, if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the time of their admission to the Provider, and (a) who were admitted to the Provider or treated as outpatients during the ninety day period following the date of such termination; or (b) who were inpatients on the date of such termination; or (c) who were admitted to the Provider *during the unexpired portion of their agreement year*

It was precisely to insure that no Blue Cross subscriber would be deprived of any prepaid benefits that the run-out provisions obligated Blue Cross to pay and the hospitals to accept full payment upon member terms for services rendered subscribers during the yet unexpired term of their individual subscriber contracts. Accordingly, it was only after a subscriber's individual contract expired upon reaching its anniversary date that the subscriber became liable to the hospital as any other paying patient for the total allocated costs of services received and Blue Cross became obligated under any subsequent renewal contract with that subscriber only to the extent of non-member benefits.

The run-out period would have ended for the last subscriber contracts on August 15, 1975, but for the passage of Act 94 which was signed effective immediately on August 2, 1975, at a time when fewer than 5% of all Blue Cross subscribers could still demand treatment from DVHC hospitals at "member" rates. In other words, the impact of Act 94 was to deprive these hospitals of an already vested right to recover from 95% of all Blue Cross subscribers, as they would from any other private paying patients, the full allocated costs of services provided. Moreover, since rights against many of these subscribers had already been implemented, a further effect of Act 94 noted by the majority below is that "[t]he hospitals are now faced with the prospect of repaying those subscribers and receiving only cost reimbursement from Blue Cross under the 1971 Contract." District Court Opinion at A12.

(Footnote 8. cont'd)
current at the termination, i.e., the date 90 days after the delivery of notice of termination under subsection 26.1 or the similar date under other sections." (Emphasis added.)

THE ISSUES ARE SUBSTANTIAL.

1. The majority below, held that "[t]he public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here." District Court Opinion at A15. Judge Luongo, dissenting, did not dispute the state's power to act in the public welfare; he recognized, however, that the state may not effect an impairment of private contract rights which is so substantial as to constitute a taking of property without just compensation "[n]o matter how great the public need." Dissenting opinion at A29.

This Court's decisions in the mortgage moratorium cases of the early 1930's clearly support Judge Luongo's conclusion that regardless of public need, a state is constitutionally prohibited from enacting legislation which retrospectively alters substantial contract rights, and not alone the remedy for enforcement of those rights.

Thus, in **Louisville Joint Stock Land Bank v. Radford,** 295 U. S. 555 (1935), the Court struck down the Frazier-Lemke Act, a federal law which would permit mortgagors to redeem property at its appraised value without reference to the actual debt outstanding, on the grounds that the forced surrender of property so long as any part of the debt secured thereby remained unpaid effected a taking of property without just compensation. It held such a taking to be constitutionally prohibited no matter how great the public need. *Id.* at 602.

The Court distinguished its approval of other moratorium measures which resulted essentially in delaying mortgagees' remedies as resting on the "assumption that no substantive right of the mortgagee was impaired, since payment in full of the debt with interest would fully compensate him." *Id.* at 581.

Accordingly, while the Court had approved in **Home Building & Loan Association v. Blaisdell,** 290 U. S. 398, 425 (1934), a Minnesota statute which extended the period of redemption but otherwise "[did] not impair the integrity of the mortgage indebtedness," it struck down the following year in **W. B. Worthen Co. v. Kavanaugh,** 295 U. S. 56 (1935), an Arkansas statute which also extended the redemption period, but permitted the mortgagor to retain possession without payment of interest, taxes, or rent. **Blaisdell** was distinguished on the grounds that those restrictive conditions in the Minnesota statute which safeguarded the substantive interest of the mortgagee in protecting his investment were absent in the **Worthen** case. *Id.* at 63.

In **Fornaris v. Ridge Tool Co.,** 423 F. 2d 563 (1st Cir. 1970), *rev'd. on other grounds* 400 U. S. 41 (1971), the case which Judge Luongo found "most nearly on point" (Dissenting Opinion at A32), the Court of Appeals for the First Circuit recast the traditional distinction between substantive and procedural rights in terms of the effective deprivation of property and went on to hold that, the police power notwithstanding, ". . . only minor infringement of established contractual rights may be effected without just compensation." *Id.* at 567.

The court then held unconstitutional as applied to contracts entered before its passage, a Puerto Rican law which prohibited a manufacturer from terminating any dealership contract unless justified by a substantial failure of performance by the dealer. The court stated, pp. 567-68:

> ". . . No amount of research by parties or amici has discovered a case suggesting that to convert a contractual relationship terminable by either party without cause into one which, short of breach by the other party, can be terminated by one of the parties only by making substantial payments and without protection for its economic interests, is not a change of great magnitude."[9]

Accord, **Superior Motors, Inc. v. Winnebago Industries, Inc.,** 359 F. Supp. 773 (D. S. C. 1973); **Globe Liquor Co. v. Four Roses Distillers Co.,** 281 A. 2d 19 (Del. 1971), *cert. denied* 404 U. S. 873 (1971).

Although plainly there will be cases where the distinction between substance and procedure is blurred or where the degree of impairment is not clearly of an unconstitutional magnitude,[10] this is hardly such a close case.

Even where the effect of Act 94 is merely to continue for ten additional months an existing contract otherwise terminable upon ninety days notice, its impact is not, as

9. This Court reversed the decision of the First Circuit at 400 U. S. 41 (1971), on the grounds that the state courts should be given an opportunity to construe the retroactive impact of the statute in a manner which might avoid the constitutional question. *Compare* **AFA Distributing Co., Inc. v. Pearl Brewing Co.,** 470 F. 2d 1210 (4th Cir. 1973) (reversing a lower court decision holding a similar statute inapplicable to existing contracts on the grounds that the state courts might construe the statute to apply retroactively such that the resulting Contract Clause issue would have to be resolved); and cf. **Mariniello v. Shell Oil Co.,** 511 F. 2d 853 (3d Cir. 1975).

10. The majority below, for example, relied on this Court's decision in **Day-Brite Lighting, Inc. v. Missouri,** 342 U. S. 421 (1952), which held that an employer may not penalize or influence an employee in the exercise of franchise rights in any way, including the docking of wages for time taken from work in order to vote.

Apart from the fact that the public interest in **Day-Brite** was the protection of fundamental rights guaranteed by the Constitution, the case is clearly distinguishable in terms of the degree of private burden involved. As noted by Judge Luongo, the financial burden upon "the net return" from a business enterprise which this Court found justifiable in **Day-Brite,** ". . . is a far cry from the plight of these non-profit hospitals which contend they are being forced to operate at inadequate and confiscatory levels of reimbursement." Dissenting opinion at A31.

the majority claims, merely to delay the hospitals' right to terminate "without penalty." District Court Opinion at A16. Rather, the hospitals are clearly penalized and deprived of property to the extent of the difference between what they otherwise would be entitled to charge for services rendered Blue Cross subscribers during that additional ten-month period and the amount recoverable for those services under the extended contract.

Nor can this loss ever be recouped in the event the hospital does not choose to negotiate a new contract with Blue Cross, since Act 94 provides absolutely no mechanism for adjusting the rate of payment for the statutory extension period unless a new contract is signed.[11]

The extent of the deprivation of property, as well as the enormity of the conractual impairment imposed by Act 94, is dramatized in the case of the Delaware Valley Hospitals whose contract with Blue Cross terminated more than sixteen months prior to the passage of Act 94. After negotiating unsuccessfully for two years, these hospitals had felt impelled to get out from under a losing contract, only to have that same contract reimposed upon them sixteen months later by legislative fiat. Moreover, as the majority itself recognized, Act 94 imposed upon these hospitals the further loss represented by the duty of "repaying those subscribers [previously billed directly for full charges] and recovering only cost reimbursement from Blue Cross under the 1971 Contract." District Court Opinion at A12.

11. At paragraph 58 of the affidavit submitted by Blue Cross, its president Bruce Taylor stated that even if no new contract is signed the hospitals will still receive full reasonable costs for services rendered subscribers during the "cooling off" period "determined by a Court, if necessary." In fact, the court below refused to make such a determination. *See* District Court Opinion at A17. However, in any event, the confiscatory effect of Act 94 must be determined apart from the availability of collateral actions for relief in federal court.

Thus, the effect of Act 94 on the Delaware Valley Hospitals is to require them to provide service for a total of 29 months, almost two and a half years, at rates which do not permit them to recover the full costs of providing such service, and with no way of recouping their losses should they resist the legislature's attempt to coerce them into negotiating a new contract with Blue Cross.

Moreover, the effect of Act 94 on the hospitals is even more outrageous when "viewed in the light of the reasonable expectations of the parties when the contract was entered into." **Fornaris,** *supra,* 423 F. 2d at 567.

In the Declaration of Necessity, Act 94 is alleged to be responsive to the expectations of Blue Cross subscribers. However, if subscribers had any legitimate expectations,[12] they derived from their subscriber contracts with Blue Cross and their reliance on Blue Cross' implicit promise that it would enroll a substantial number of hospitals as members. Moreover, it is Blue Cross which has reaped a financial windfall when, because of its failure to negotiate member hospital agreements, it became liable to its subscribers only to the extent of the normally much smaller non-member benefits.

Thus, while Blue Cross might very well have expectations that it would be called upon to cover its subscribers' costs of hospitalization in the event it was unable to negotiate member hospital agreements, the hospitals—which have never solicited or contracted with Blue Cross subscribers and have received no consideration from them—

12. As was stressed repeatedly below, implementation of the run out provisions insured that no subscriber was deprived of prepaid benefits. Moreover, any subscriber who renewed Blue Cross coverage after July 31, 1974, did so with full knowledge that Blue Cross would pay only non-member benefits in connection with claims for services provided by the Delaware Valley Hospitals, and did so in preference to purchasing commercial insurance which has been available at all times and provides indemnity coverage for full hospital charges.

certainly can not be charged with any *reasonable* expectation that if they refused to accept a contract on Blue Cross' terms, they would have to accept legislative imposition of these very same terms.

Particularly in light of the parties' reasonable expectations, then, it cannot be seriously doubted that, at least in its retrospective application to terminated and pre-existing contracts, Act 94 effects a substantial impairment of contract and an uncompensated taking of property condemned by both the Contract and Due Process Clauses of our Constitution.

While the Court need not reach this issue if it finds Act 94 repugnant to the Constitution only in its retrospective effect, appellants reserve the right to argue, either on remand to the district court or in a future state court proceeding, that Act 94 is not severable and must fall in its entirety.[13]

2. Appellees argued below that Act 94 is no more than a piece of rate regulation. Assuming *arguendo* that this is true, though it clearly is not (*see* Dissenting Opinion at A31), Act 94 must fall still as an unconstitutional taking of property without just compensation.

Appellants' affidavits—which the court below was required to accept as true upon appellees' motion for summary judgment—establish that the contracts extended and reinstated by Act 94 are confiscatory contracts under which the hospitals are unable to recover from Blue Cross the share of the hospitals' true costs of doing business properly allocable to services rendered Blue Cross sub-

13. Appellants argued below that the retrospective and prospective applications of Act 94 are so closely intertwined as a matter of both legislative intent and statutory construction that severance would be impossible. Therefore, the Act being clearly unconstitutional in its retrospective application, the entire statute must fall. *See, e.g.*, **Sloan v. Lemon, 413 U. S. 825 (1973); Saulsbury v. Bethlehem Steel Co., 413 Pa. 316 (1964).**

scribers. Since it is clear that even public utilities may not be compelled to provide service at less than a fair rate of return, **Denver Union Stock Yard Co. v. United States, 304 U. S. 470 (1938); D. C. Transit System, Inc. v. Washington Metropolitan Area Transit Commission, 466 F. 2d 394 (D. C. Cir.), *cert. denied* 409 U. S. 1086 (1972)**, then certainly private hospitals, and particularly non-profit hospitals, may not be forced by the state to provide service under contracts which do not reimburse them their full allocated costs of providing that service. Moreover, it is clear that under general public utility law, the courts have recognized as operating expenses properly considered in setting reasonable rates such cost of doing business as uncollectible customer accounts. *See e.g.*, **Solar Electronic Co. v. Pa. P. U. C., 137 Pa. Superior Ct. 325, 379 (1939); Chambersberg Gas Co. v. P. U. C., 116 Pa. Superior Court 196, 224-25 (1935).**

The majority below met this contention with three different arguments, none of which is responsive to the uncontested fact that appellant hospitals cannot recover under the extended and reinstated contracts with Blue Cross that proportionate share of their total cost of doing business which they must recover from or on behalf of every private paying patient if they are to remain in business.

(a) The first grounds upon which the majority responded to appellants' contention that the cost reimbursement formula imposed upon them by Act 94 is confiscatory, was that "[t]he validity of such clauses in Blue Cross-hospital contracts has already been upheld." District Court Opinion at A16. The majority then claimed to see nothing in the instant challenge to distinguish it from **Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F. 2d 80 (3d Cir. 1973)**, a case involving

claims by a private insurer that contract arrangements between Blue Cross of Western Pennsylvania and various hospitals violated the antitrust laws.

It does not require elaborate argument to expose the flaw in the majority's use of the **Travelers'** case. It suffices to say that the Court of Appeals' holding in **Travelers** that ". . . the economic inducements which made the Blue Cross contract acceptable to hospitals did not amount to 'coersion,'" so as to constitute unlawful conduct under the antitrust laws, 481 F. 2d at 84, does not speak to the issue of whether the legislature may impose those same contract terms upon hospitals by statute without running afoul of the Constitution.

In fact, if **Travelers** has any meaning here at all, it is that whether or not a private party voluntarily chooses to enter a contractual relationship has nothing whatever to do with the objective fairness of the contractual terms. Thus, the fact that appellant hospitals voluntarily entered the non-compensatory Delaware Valley Agreement in 1971 is irrelevant to the power of the Pennsylvania legislature to impose the same agreement on appellant hospitals in 1976.

(b) A second ground advanced by the majority in support of its granting appellees' motion for summary judgment on the confiscation issue is that "[t]he affidavits of plaintiff are far too generalized to justify the grant of summary judgment in their favor." District Court Opinion at A20.

At the very least, one would agree with Judge Luongo that if the affidavits are not conclusive, they at least raise material issues of fact requiring trial. Dissenting Opinion at A29, n. 1. The law is quite clear in this respect that the filing of cross-motions for summary judgment in no way alters the burden upon each party to establish its entitlement to judgment as a matter of law upon genuinely undisputed facts. **Rhoads v. McFerron,** 517 F. 2d 66 (2d Cir. 1975); **Weiss v. Kay Jewelry Stores, Inc.,** 470 F. 2d 1259 (D. C. Cir. 1972); **Rains v. Cascade Industries, Inc.,** 402 F. 2d 241 (3d Cir. 1968).

More important, the majority below did not explain why, simply because Blue Cross does not require the hospitals to undertake those expenses such as indigent patient care for which it refuses to pay, "plaintiffs have failed to show that the expenses incurred by plaintiffs under Act No. 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement." District Court Opinion at A21. This is to suggest that the hospitals have not been harmed because if they simply did not provide care to indigents or others whose ability to pay was in question, including Blue Cross subscribers once their coverage had lapsed,[14] and if they otherwise permitted Blue Cross to determine the extent of their community responsibility, then the Blue Cross reimbursement formula imposed upon the hospitals by virtue of Act No. 94 would be fully compensatory. The court accepted, in other words, that Blue Cross somehow has the right to determine the proper expenses of running a hospital.

The majority, thus, refused to recognize that the hospitals have any obligation which must be taken into account in mandating charges to provide indigent patient care or other forms of community service. This position is

14. A large proportion of the hospitals' bad debts result from the unpaid bills of patients who enter the facilities as Blue Cross subscribers and then have their coverage lapse during the course of their hospitalization. The Blue Cross reimbursement formula does not recognize or reimburse any portion of these uncollectible charges. Williamson Affidavit, paragraph 4. Thus, at the same time that Blue Cross refuses to assume any fiscal responsibility for the hospitals' costs of treating indigents, it imposes upon others the responsibility for the hospitals' costs of treating patients who initially demanded services as Blue Cross subscribers.

ironic in view of the fact that the majority found Act 94 justified in the first instance because hospitals are institutions affected with the public interest and the presumed unavailability of hospital services is a crisis which would justify otherwise unconstitutional legislative intervention. *See e.g.*, District Court Opinion at A14-A15.

It also ignores the fact, which appellants would have thought to be a subject of judicial notice, that from its pre-Christian origins until the present day, the hospital has developed as a social and charitable institution which has never existed as the purely rational economical entity the lower court would have it be. *See generally* E. Churchill, "The Development of the Hospital," in THE HOSPITAL IN CONTEMPORARY SOCIETY (N. Faxon, *ed.* 1946).

Moreover, if the European hospital was historically a charitable institution endowed by the rich for the use of the poor, *See generally* H. Burdett, HOSPITALS AND ASYLUMS OF THE WORLD (1893) Vol. III; Churchill, *supra*, the American hospital developed from the start as a humanitarian and truly social institution supported by all classes of society for the benefit of society as a whole. American hospitals tempered the charitable ideal with the principle that it was important to the patients' self respect that they pay whatever they were able to. Accordingly, hospital charges in this country have always been graded to the individual patient's income level. M. Risley, THE HOUSE OF HEALING (1961) at p. 226.

It is anathema to this ideal and to the development of the hospital generally as a social institution, for Blue Cross to suggest that it can isolate the incremental cost of services to its subscribers from the overall costs to the hospital of discharging its historic duty of service to the community.

(c) Ultimately, the majority contended that whether or not the contractual rate of payment imposed by Act 94 is

confiscatory is a matter for "the legislative process as distinguished from judicial inquiry," which matter, it determined, had been delegated by the legislature under Act 94 itself to be resolved by the Insurance Department. District Court Opinion at A17.

This argument not only fails to comprehend the role assigned the Insurance Department under Act 94, but misconceives the role of the federal judiciary under the Constitution of the United States.

It is plain that the Insurance Department has no duty under Act 94 to assure that payment under the extended or reinstated contracts is reasonable. More important, it has no power to order any retroactive adjustment of payments except insofar as the Act itself provides that *if* a new contract is negotiated, its terms shall apply retroactively to the date of termination of the prior agreement. Thus, even if the Insurance Commissioner did find the contracts imposed by Act 94 to be confiscatory—and his recommendation of a "plus factor" in the earlier negotiations suggests that he did not find to the contrary—the most he could do would be to cut short the period of time for which he has authority under Act 94 to suspend the hospitals' right of termination.

In other words, the Insurance Department has power under Act 94 to exascerbate the confiscatory impact of the imposed contracts, but no power to relieve it.

Under these circumstances, the court below plainly was obligated to hear and resolve appellants' claim that the rate of payment effectively imposed upon them by Act 94 is confiscatory and constitutes an uncompensated taking of property prohibited by the United States Constitution.

3. Many of the most serious defects in the majority's legal reasoning may be traced to a single factual error, *i.e.*, that appellant hospitals are regulated entities. While the

majority was not willing to endorse in so many words Blue Cross' argument that Act 94 is simply a piece of rate regulation, it did accept all the erroneous factual premises necessary to that theory.

It is simply *not* true that hospitals entering contracts with Blue Cross must be approved by the Department of Public Welfare (*see* District Court Opinion at A8, A21-A22).[15] Nor is it true that by entering such a contract, the hospitals become subject to regulation by the Insurance Department (*see* District Court Opinion at A21, A22). Rather 40 Pa. C. S. § 6124(a) provides only that the Insurance Department shall have authority to approve certain transactions of hospital plan corporations authorized under that chapter, which transactions include contracts negotiated by hospital plan corporations with hospitals. Thus, it is only to the extent that a hospital joins in the submission of such a contract for the approval of the Insurance Department, that it is subject to either regulation or the jurisdiction of the Insurance Department or any other regulatory or administrative body.

Nonetheless, the majority below distinguished the decision in **Fornaris v. Ridge Tool Co.**, *supra*, on the grounds that "their [the hospitals] expectations as a regulated industry are different from those of the commercial manufacturers in **Fornaris**." District Court Opinion at A16. Moreover, it analogized that effect of Act 94 which requires that appellants refund subscriber payments lawfully due

15. 40 Pa. C. S. § 6121 contains the following definition of hospitals "eligible" to enter contracts with Blue Cross:

§ 6121. Eligible hospitals

Any hospital plan corporation may enter into contracts for the rendering of hospitalization to any of its subscribers only with hospitals operated by the Commonwealth, or its agencies, or by political subdivisions, or by corporations organized under the laws of this Commonwealth for hospital purposes, or with such other hospitals as are approved by the Department of Public Welfare.

and remitted prior to the enactment of Act 94 to "remedial measures in other regulatory statutes" as, for example, when carriers are required to "refund, with interest, increased rates found to be not justified." District Court Opinion at p. A19, n. 12 and accompanying text.

What is most bizarre about this theory—beside its irrelevance to the facts—is that if the hospitals were regulated in fact, they would have been afforded those fundamentals of due process—both procedural and substantive—which they have been denied here.

Implicit in the assumption of regulation is the belief that there is some regulatory body required to take into consideration the interests of the regulated party and from which that party may seek relief from an onerous exactment. Thus, for example, the majority assumed the Insurance Department was authorized to consider and adjust the adequacy of payment under the reinstated contracts. However, as noted above, the Insurance Department lacks the power to effect any change in the contract rates. Nor is there any other regulatory agency in any way charged with overseeing appellants' interests.

Moreover, there is every reason to believe, as the dissent suggests, that the legislature, itself, never considered the hospitals' interests, but evidenced in Act 94 "an unfortunately hasty reaction" to the complex problem spawned by the Blue Cross contract dispute. Dissenting Opinion at A33.[16]

Appellants here have no recourse but to the courts to draw the constitutional limits on the extent to which private parties may be required to bear the burden of the presumed

16. In contrast, this Court relied upon the legislature's "conscientious effort and thoroughness" in studying the factual circumstances which led to the purely prospective regulation upheld in **Nebbia v. New York**, 291 U. S. 502, 516 (1934), a case cited repeatedly by the majority below.

public welfare. For the majority then to declare, in effect, that the Constitution bows to the judgment of the Pennsylvania legislature even when, as here, it allows itself to be manipulated by a private interest, constitutes not only a radical departure from established precedent, but an abdication of judicial responsibility which this Court ought to note jurisdiction to rectify.

CONCLUSION.

Wherefore, for all of the above reasons, it is respectfully submitted that the Court ought to note probable jurisdiction to review and reverse the decision from which this appeal is taken.

Respectfully submitted,

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APPENDIX A.

STATUTE INVOLVED.

Session of 1975

Nonprofit Hospital Insurance Plans

Act No. 94

H. B. NO. 1347

An Act amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing the Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1.

Section 6124 of Title 40, act of November 25, 1970 (P. L. 707, No. 230), known as the Pennsylvania Consolidated Statutes, added November 15, 1972 (P. L. 1063, No. 271), is amended by adding a subsection to read:
§ 6124. Rates and contracts [98]

• • •

98. 40 Pa. C. S. A. § 6124 subsec. (c).

(c) Maintenance of contractual relationships.—

(1) Declaration of necessity.—It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.

(2) Notification period.—No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.

(3) Hearing period.—Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the

termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) Negotiation period.—If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of the hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan

corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) Retroactivity.—Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2.[99]

The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C. S. Chap. 61 (relating to hospital plan corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3.[1]

This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

Approved the 2nd day of Aug. A. D. 1975.

99. 40 Pa. C. S. A. § 6124 note.

1. 40 Pa. C. S. A. § 6124 note.

APPENDIX B.

OPINION OF THE DISTRICT COURT.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA.

Civil Action No. 75-2306.

PAUL I. GUEST,
President of Methodist Hospital;
CHARLES H. FRENZEL, Executive Vice President
of Mercy Catholic Medical Center;
PHILIP J. SAWLINSKY, Manager of Patient Accounts
of ST. JOSEPH'S HOSPITAL; and
METHODIST HOSPITAL, on Behalf of Themselves
. and All Others Similarly Situated

v.

EMMETT F. FITZPATRICK, JR.,
District Attorney of Philadelphia,
ROBERT P. KANE, Attorney General of the
Commonwealth of Pennsylvania, Individually and
in Their Official Capacities, and
BLUE CROSS OF GREATER PHILADELPHIA.

Before VAN DUSEN, *Circuit Judge*, and
LUONGO and WEINER, *District Judges*.

WEINER, *J.* February 27, 1976

This is an action brought by several hospitals, members of the Delaware Valley Hospital Council (hereinafter

DVHC) for declaratory judgment and injunctive relief, challenging the provisions of a Pennsylvania law, Act No. 94, 40 Pa. C. S. § 6124(c), effective August 2, 1975. Act No. 94 creates statutory requirements for the termination of contracts between hospitals and certain hospital plan corporations. Jurisdiction of this Court was invoked pursuant to 28 U. S. C. § 1331, and 28 U. S. C. § 1343(3), and a three-judge court was convened as required by 18 U. S. C. § 2284. The court has for its consideration cross motions for summary judgment filed by plaintiffs and defendants respectively.[1]

Since the facts are not in dispute, there remain solely questions of law. From our examination of the record, the following facts emerge: On August 15, 1974, the contract between defendant Blue Cross of Greater Philadelphia and plaintiff hospitals expired. Run-out provisions of the contracts between Blue Cross and individual subscribers then began to take effect, and coverage expired on the anniversary dates of the subscription contracts. The last subscriber contracts were to run out on August 15, 1975. During the one-year following expiration of the above contract, negotiations toward a new contract proved to be unsuccessful. The effect of the run-out provisions would have been to limit most subscribers' coverage to that afforded in non-Blue Cross member hospitals. Traditionally, an individual enters into a subscription contract with Blue Cross. In the majority of cases, the insurance plan will obtain hospital services in member

1. Due to a stipulation filed 9/25/75, stating that defendants Fitzpatrick and Kane agree not to seek criminal sanctions while Act No. 94 remains subject to constitutional challenge but apparently reserving their right to proceed against plaintiffs after final determination of this suit, there is a case or controversy continuing insofar as plaintiffs seek final injunctive relief. The absence of any demand for damages requires that the Pennsylvania defendants' claims for immunity under the Eleventh Amendment be rejected. See *Edelman v. Jordan*, 415 U. S. 651, 664-65 (1974).

hospitals. The coverage afforded is then either complete coverage, i.e., the full hospital service is provided, or the subscriber pays a relatively small portion of the hospital fee. In either event, Blue Cross makes direct payment to the hospital. If the subscriber is admitted to a hospital which is not a member hospital, the subscriber will be fully responsible for his hospital costs and Blue Cross will partially reimburse the subscriber directly. Typically, only a small portion of the total hospital bill is repaid to the subscriber.

In situations in which total coverage is provided subscribers, it is clearly necessary that there be a contractual relationship between Blue Cross and the hospitals. Hence, the term "member hospitals". The contract between Blue Cross and its member hospitals operates on a cost reimbursement formula. Under such a formula, the retail price of hospital services is not paid by Blue Cross. Rather, Blue Cross reimburses hospitals for the cost to the hospitals of providing care to the subscriber, computed in a way that allows, inter alia, for consideration of depreciation and economic inflation factors.

It was the cost reimbursement formula that led to the breakdown of negotiations for new contracts between Blue Cross and the plaintiff hospitals who are represented by the DVHC.

During the one-year period of negotiations, increasing numbers of subscribers lost member hospital benefits in the plaintiff hospitals. On August 2, 1975, the Pennsylvania legislature passed, and the Governor signed, Act No. 94, 40 Pa. C. S. § 6124(c).

Chapter 61 of Title 40 establishes statutory control over hospital plan corporations. Defendant Blue Cross of Greater Philadelphia is a hospital plan corporation within the meaning of the statute. The Hospital Plan Corporation

Act generally provides for regulation of hospital plan corporations and specifically requires, *inter alia*, that all hospital plan corporations obtain certificates of authority from the Pennsylvania Department of Insurance (§ 6102(a)); that hospital plan corporations enter into contracts only with hospitals approved by the Department of Public Welfare (§ 6121).

Section 6124 of the Hospital Plan Corporation Act, which section Act No. 94 amends, provides:

> (a) The rates charged to subscribers by hospital plan corporations, all rates of payments to hospitals made by such corporations pursuant to the contracts provided for in this chapter, all acquisition costs in connection with the solicitation of subscribers to such hospital plans, the reserves to be maintained by such corporations, the certificates issued by such corporations representing their agreements with subscribers, and any and all contracts entered into by any such corporation with any hospital, shall, at all times, be subject to the prior approval of the department.
>
> (b) Every application for such approval shall be made to the department in writing . . .

Act No. 94 which amends the above section, provides:

> Section 1. Section 6124 of Title 40, . . . is amended by adding a subsection to read:
>
> § 6124. Rates and contracts
>
> (c) Maintenance of contractual relationship.
>
> (1) *Declaration of necessity*—It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that

> it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits pre-paid by them through payments of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospital entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.
>
> (2) *Notification period*—No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.
>
> (3) *Hearing period*—Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days no-

tice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) *Negotiation period*—If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department.

If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) *Retroactivity*—Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2. The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occuring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 . . . . Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3. This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

The effect of Act No. 94 on the Plaintiff hospitals is to reinstate the most recent contract between the DVHC represented hospitals and Blue Cross as of its original termination date, namely, August 15, 1974. If the hospitals wish to terminate the contract, they must follow the provisions of the Act. If a new contract is negotiated by the parties and approved by the Insurance Department, that new contract will date back to the termination of the previous agreement. However, since August, 1974,[2] the hospitals have been requiring Blue Cross subscribers to pay for hospital care as is the practice in non-member hospitals. The hospitals are now faced with the prospect of repaying those subscribers and receiving only cost reimbursement from Blue Cross under the 1971 Contract.[3]

The hospitals' contention is that Act No. 94 violates their Constitutional rights. They claim that the retroactivity of the Act, which reinstates the contract which expired on August 15, 1974, is in violation of the Contract Clause and of the Due Process Clause of the United States Constitution. Specifically, the hospitals claim that the Act effects an unconstitutional taking of property without just compensation and also violates the Equal Protection Clause of the United States Constitution.

The Contract Clause, Article I, § 10 of the United States Constitution provides that no State shall pass any law impairing the obligation of contracts. The plaintiff-hospitals' contention is that Act No. 94 constitutes a

2. This date is, of course, variable, because of the run-out provisions of subscribers' contracts.

3. The contract which expired on August 15, 1974 was entered into in 1971 and amended in 1972.

"wholesale evisceration of plaintiffs' contractual rights of termination". We believe that this is not the case at all here.

The Contract Clause came into widespread use in litigation during the depression years when many States passed statutes designed to aid financially distressed citizens, unable to satisfy previously entered-into contractual obligations. The case of *Home Building and Loan Assn. v. Blaisdell, et al.*, 290 U. S. 398 (1933) sets forth the standards to be applied to state legislative enactments to determine whether or not such legislation offends the Contract Clause. At issue in that case was the 1933 Minnesota Mortgage Moratorium Law which provided relief from mortgage foreclosure during a declared emergency. In its opinion up-holding the statute, the Supreme Court stated:

> "Not only are existing laws read into contracts in order to fix obligations as between the parties, but the reservation of essential attributes of sovereign power is also read into contracts as a postulate of the legal order. The policy of protecting contracts against impairment presupposes the maintenance of a government by virtue of which contractual relations are worth while,—a government which retains adequate authority to secure the peace and good order of society. The principle of harmonizing the constitutional prohibition with the necessary residuum of state power has had progressive recognition in the decisions of this Court." *Id.* at 435.

The plaintiffs' argument is, in essence, that the statutory extension period violates their contract right of termination on ninety days notice as to any contract entered into between the hospitals and Blue Cross. We

are of the opinion that the public interest of preserving the health of the citizens of Pennsylvania adequately justifies such a measure.[4] More than 50% of the citizens have health care insurance coverage through Blue Cross. Most, if not all, of these policyholders, it can be assumed, maintain Blue Cross insurance because of the virtually complete coverage offered by Blue Cross at member hospitals. The current contract dispute, with the resulting run-out of subscribers' member hospital coverage eliminated many hospitals in the Philadelphia area from member hospital status.[5] Therefore, numerous Pennsylvanians who had prepaid and expected member hospital subscriber coverage, found their coverage reduced to non-member coverage at many hospitals.

The maintenance of the health and general well-being of its citizens has been found to be a legitimate state concern and has formed the basis of numerous judicial decisions up-holding state legislative action.[6] Likewise, in this case, it is precisely because the public interest is so substantial in the area of health care that legislation gov-

4. The case of *Travelers Insurance Co. v. Blue Cross of Western Pa.*, 361 F. Supp. 774 (W. D. Pa. 1972), *aff'd* 481 F. 2d 80 (3d Cir. 1973), *cert. denied* 414 U. S. 1093 (1974), sustained the general provisions of Blue-Cross hospital contracts against charges of violation of the antitrust laws. In that case, it was stated that a study of the health care problem in Pennsylvania by the Pennsylvania Economy League showed that ". . . it was common for people to forego needed hospitalization because they lacked money to pay the bills." 361 F. Supp. 774, 776.

5. Thirty-seven (37) hospitals in the Philadelphia area are represented by the DVHC. Non-member hospital coverage for subscribers is approximately 25% of hospital costs.

6. See e.g., *Nebbia v. New York*, 291 U. S. 502 (1934) in which regulation of the sale price of milk authorized by a New York statute was upheld as being reasonably related to the goal of protecting the welfare of the citizens of New York. In its opinion, the Supreme Court stated that support for this statute could be found from the fact that the milk industry in general was heavily regulated in New York.

erning hospitals and hospital plan corporations has been enacted in Pennsylvania.[7] Act No. 94 is a logical and reasonable extension of that legislation.

We have carefully considered the cases cited by our brother Judge Luongo and find them to be distinguishable.[8] The Supreme Court, in *El Paso v. Simmons*, 379 U. S. 497 (1965), stated that it has long been recognized that state legislatures have the power to safeguard the vital interests of their citizenry.[9] The distinction to be drawn is not solely between legislation of substantive and remedial contract provisions but, rather, between legislation which affects contractual rights and obligations in purely commercial enterprises and legislation which concerns the health and welfare of the people. The need of Pennsylvanians for medical insurance which enables them to receive hospital care during health crises is a need which will, unfortunately, touch most citizens during their lifetimes. The public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here.

In *Fornaris v. Ridge Tool Co., et al., supra*, the Court of Appeals found unconstitutional a Puerto Rican statute which provided that contracts between manufacturers and dealers, regardless of their terms, were, with certain exceptions, to be renewable at the option of the dealer and which imposed substantial damages on manufacturers who refused to accede. The court found that the new contractual obligations were excessive in light of the reasonable expectations of the parties. Here in contrast the con-

7. 40 Pa. C. S. § 6101, *et seq.*

8. *Fornaris v. Ridge Tool Co., et al.*, 423 F. 2d 563 (1st Cir. 1970), rev'd. on other grounds, 400 U. S. 41 (1971); *Superior Motors, Inc. v. Winnebago Industries, Inc.*, 359 F. Supp. 773 (D. S. C. 1973).

9. *Id.* at 508.

tracts are still terminable at the end of approximately one year by the hospitals without penalty and their expectations, as a regulated industry are different from those of the commercial manufacturers in *Fornaris*.

Plaintiffs further contend that Act No. 94 violates the Due Process and Equal Protection Clause of the United States Constitution. Their argument is based in part on the theory that the cost reimbursement formula contained in the Blue Cross-hospital contracts does not include such items as indigent care, charity allowances, uncollectible amounts or research costs and thereby renders the contracts non-compensatory and constitutes a taking of property without just compensation. The validity of such clauses in Blue Cross-hospital contracts has already been upheld.

The case of *Travelers Insurance Company v. Blue Cross of Western Pennsylvania, supra*, upheld Blue Cross-hospital contracts against claims by a commercial insurer that the contractual arrangements between Blue Cross of Western Pennsylvania and hospitals violated the antitrust laws. Specifically, Travelers contended that Blue Cross was a dominant competitor monopolizing the hospital insurance industry by pressuring hospitals to enter into contractual arrangement which favored Blue Cross over other commercial insurers. The favored treatment claim arose from the failure of Blue Cross-hospital contracts to include in the reimbursement formula such items as indigent care, and the resulting lower cost to Blue Cross for hospital services. The court, in its opinion, upholding the above-mentioned contract clauses stated that the Insurance Department had mandated a ceiling on cost reimbursement, and the exclusion from the reimbursement formula of the cost of free care and capital expansion. We see nothing in the challenge to cost reimbursement formula in

the instant case to distinguish it from the reimbursement terms found to be valid in *Travelers*.

We note that the court stated with reference to the Pennsylvania Hospital Plan Corporation Act (40 Pa. C. S. A. § 6106 ff.) in *Travelers, supra*, at page 86 of 481 F. 2d:

> "In view of our holding that, independent of the McCarran-Ferguson Act, the antitrust laws were not violated, the state of Pennsylvania has not denied Travelers equal treatment in violation of the Fourteenth Amendment. Furthermore, even if McCarran-Ferguson Act protection were necessary to Blue Cross, the facts do not support the proposition that Pennsylvania's regulation of the contract between Blue Cross and the hospitals was without rational purpose, *see, e.g., James v. Strange*, 407 U. S. 128, 92 S. Ct. 2027, 32 L. Ed. 2d 600 (1972)."

In addition, plaintiffs claim that the loss sustained by virtue of the fact that the above-mentioned costs are not reimbursed is further exacerbated by the ceiling limitation on reinstatement of allowable costs. The question of the economic viability of hospitals as a result of the reinstatement of the previously-terminated contract is a matter for the legislative process as distinguished from judicial inquiry. Under the Hospital Plan Corporation Act, the Insurance Department is authorized to approve or disapprove proposed contracts pursuant to specific guidelines.[10] Act No. 94 itself provides that during the suspension period, the Insurance Department shall either approve termination of the contract or shall ". . . recommend such terms of continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its

10. 40 Pa. C. S. § 6124(a) & (b).

costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost." [11] Plaintiff hospitals have filed a Notice of Intent to Terminate with the Insurance Department and have so notified Blue Cross. Therefore, the question of the non-compensatory nature of the reinstated contract is one to be determined by the Insurance Department.

Plaintiffs argue that Act No. 94 is subject to challenge on constitutional grounds predicated upon the theory that the retroactive application of the statute constitutes a taking of property without due process and plaintiffs further reiterate their previous argument of "impairment of contract." Here, the plaintiffs focus upon the provisions of Act No. 94 which, in substance and effect, provide: (a) that contracts between the hospitals and Blue Cross which terminated in August 1974 be reinstated and (b) that, as a result, subscribers who paid in full for hospitalization during the eleven and a half month period preceding the passage of Act No. 94 be reimbursed for all charges which would have been reimbursed to subscribers under the 1971 Agreement. We find that the statutory reinstatement of terminated contracts and their cost reimbursement formulae and the resulting mandatory reimbursement of subscribers are not unconstitutional.

The unanticipated inability of Blue Cross and the hospitals to negotiate a new contract in 1974 created extreme financial hardship for Blue Cross subscribers hospitalized after the contractual run-out provisions had taken effect. Act No. 94 is designed to avoid the recurrence of such a situation in the future. As part of the remedial nature of the statute, hospitals with long-standing contracts with Blue Cross were required to reinstate the most recent contract provisions. This remedial measure is

11. 40 Pa. C. S. § 6124(c)(3).

strikingly similar to remedial measures in other regulatory statutes regarding disputed rates charged by regulated corporations.[12] In *Fleming v. Rhodes*, 331 U. S. 100 (1947), the Supreme Court held that rights previously acquired can be legislatively reinstated retroactively. Here, subscribers contracted with and prepaid Blue Cross for health care coverage. As part of that contract, hospitalization at member hospitals was to be provided at little or no cost to the subscriber. The crisis created by the failure of contract negotiations between Blue Cross and the hospitals placed a heavy burden on subscribers. Act No. 94, in its declaration of necessity, states that subscribers are entitled to receive benefits for which they have paid in advance. The subscribers hospitalized between August, 1974 and August, 1975 did not receive those health care benefits. Act No. 94 simply places them in the same position as subscribers hospitalized prior to August, 1974 and subsequent to August, 1975.

The retroactive effect of statutes has been approved where they have filed gaps in the regulatory scheme. See *Fleming v. Rhoades, supra;* C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692 (1960). The Supreme Court has recognized in the labor field that contractual arrangement may be "continued for a time while further efforts [are] made to settle the dispute." See *Steelworkers v. United States*, 361 U. S. 39, 41 (1959). Further, the Supreme Court has held that the taking of property under a program clearly in the public interest is not a denial of due process of law, using this language in *Day-Brite Lighting, Inc. v. Missouri*, 342 U. S. 421, 424-25 (1952):

12. For example, the Interstate Commerce Act, 49 U. S. C. § 15(7) authorizes the ICC to require that carriers refund, with interest, increased rates found to be not justified. And, in *Nebbia v. New York, supra*, a New York statute authorizing the Milk Control Board to fix milk prices in the state was upheld.

"Of course many forms of regulation reduce the net return of the enterprise; yet that gives rise to no constitutional infirmity. [Citing cases.] Most regulations of business necessarily impose financial burdens on the enterprise for which no compensation is paid. Those are part of the costs of our civilization . . . . The public welfare is a broad and inclusive concept. The moral, social, economic, and physical well-being of the community is one part of it; the political well-being another. The police power which is adequate to fix the financial burden for one is adequate for the other. The judgment of the legislature that time out for voting should cost the employee nothing may be a debatable one. It is indeed conceded by the opposition to be such. But if our recent cases mean anything, they leave debatable issues as respects business, economic, and social affairs to legislative decision. We could strike down this law only if we returned to the philosophy of the *Lochner, Coppage* and *Adkins* cases."

The affidavits of plaintiff are far too generalized to justify the grant of summary judgment in their favor. Although the dissenting opinion alleges that plaintiff-hospitals "are compelled to operate at charges they contend are below the level of operating expenses . . . and that are . . . confiscatory," the affidavit of Mr. Armstrong in support of plaintiffs' Motion for Summary Judgment, at paragraph 6, objects to the failure of defendant to pay "the expenses incurred by the hospital in providing care to indigents, in writing off uncollectible accounts other than those of Blue Cross subscribers, in providing charity allowances, and in undertaking certain educational and research activities." Cf. paragraph 61 of supplemental

affidavit of Bruce Taylor dated October 14, 1975. Defendant does not require plaintiffs to undertake such expenses, so that plaintiffs have failed to show that the expenses incurred by plaintiffs under Act No. 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement. The affidavits filed by plaintiffs fail to show with any specificity that the cause of their anticipated losses is Act No. 94, as opposed to their desire to provide service for their communities in accordance with the standards of the American Hospital Association (see, for example, page 18 of Plaintiffs' Memorandum, referring to the cost of "educational and research programs, credit losses, and the care of [indigent] patients . . .", and paragraph 15 of Mr. Armstrong's affidavit referring to "health care services required to maintain its accreditation" without making specific such generalities).

Plaintiffs' equal protection arguments are founded on the claim that Act No. 94 imposes burdens only on member hospitals, leaving non-member hospitals unregulated. It is true that neither Act No. 94 nor the Hospital Plan Corporation Act regulates non-member hospitals. The obvious reason seems to be that the Hospital Plan Corporation Act regulates hospital plan corporations and those hospitals with whom they contract. As a result of the agreements between hospitals and hospital plan corporations, members of the general public enter into contractual agreements with the hospital plan corporation for the provision of health care benefits at member hospitals. Hospital plan corporations are required to receive certification from the Pennsylvania Insurance Department.[13] Hospitals which enter into agreements with

13. 40 Pa. C. S. § 6102.

hospital plan corporations likewise must be approved by the Department of Public Welfare.[14]

And, finally, contracts between hospital plan corporations and hospitals must receive Insurance Department approval.[15] Whereas member hospitals provide virtually total coverage for hospitalization and health care, and are reimbursed under the approved contract formula by Blue Cross, non-member hospitals receive full payment from subscribers, who are then only partially reimbursed by Blue Cross.

The determination of the legislature to regulate only member hospitals by Act No. 94 is not violative of equal protection. Under the equal protection clause, the test applied to any classification scheme set up by a state legislative body is whether the scheme has a rational basis.[16] The burden is on plaintiffs to show that the classification scheme has no rational basis. Since non-member hospitals, by definition, have no contractual arrangement with Blue Cross, they were not included in a statute which regulates hospital plan corporations and, as incident to that regulation, hospitals with whom the corporations contract. In *Nebbia v. New York, supra,* appellant claimed that a New York statute authorizing establishment of minimum resale prices of milk for stores denied him equal protection because it enabled door-to-door distributors to provide additional services at an almost identical price. Specifically, the Milk Control Board had fixed the minimum price to be charged by a store and by a distributor for a quart of milk at nine and ten cents respectively. In its opinion, the Supreme Court stated: "But if it were shown that the appellant is compelled to buy [from a wholesale

14. 40 Pa. C. S. § 6121.

15. 40 Pa. C. S. § 6124.

16. See e.g., *German Alliance Insurance Company v. Hale,* 219 U. S. 307 (1911).

distributor and not directly from a farmer] the difference in the retail price he is required to charge his customers, from that prescribed for sales by distributors, is not on its face arbitrary or unreasonable, for there are obvious distinctions between the two sorts of merchants which may well justify a difference of treatment, if the legislature possesses the power to control the prices to be charged for fluid milk." Id. at 521. Because of the substantial difference in subscriber benefits provided by member and non-member hospitals here, it cannot be gain-said that the statutory distinction has no reasonable basis.

The foregoing shall constitute the findings and conclusions of the court on the plaintiffs' motion for injunctive relief, and such motion will be denied. The joint motions of defendants Blue Cross, Fitzpatrick, Kane and the Insurance Department for summary judgment will be granted, and the motions of plaintiffs for summary judgment will be denied.

ORDER OF THE DISTRICT COURT.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF
PENNSYLVANIA.

Civil Action No. 75-2306

PAUL I. GUEST,
President of Methodist Hospital;
CHARLES H. FRENZEL, Executive Vice President
of Mercy Catholic Medical Center;
PHILIP J. SAWLI. SKY, Manager of Patient Accounts
of ST. JOSEPH'S HOSPITAL; and
METHODIST HOSPITAL, on Behalf of Themselves
and All Others Similarly Situated

v.

EMMETT F. FITZPATRICK, JR.,
District Attorney of Philadelphia,
ROBERT P. KANE, Attorney General of the
Commonwealth of Pennsylvania, Individually and
in Their Official Capacities, and
BLUE CROSS OF GREATER PHILADELPHIA

ORDER

The motion of Plaintiffs for summary judgment is DENIED.

The motions of defendants for summary judgment are hereby GRANTED.

IT IS SO ORDERED.

/s/ FRANCIS L. VAN DUSEN
Francis L. Van Dusen
/s/ CHARLES R. WEINER
Charles R. Weiner

APPENDIX C.

DISSENTING OPINION.

LUONGO, J., dissenting

I agree that this is a matter which affects the health and welfare of the citizens of Pennsylvania. I agree also that the aim of this legislation—to protect the ultimate consumers' need for continued hospital plan protection—is commendable and is certainly within the police power of the state. In my view, however, the legislation misses the constitutional mark when it requires the hospitals to remain parties to the contract beyond the bargained for notice period without making some provision to compensate them for the losses they may incur during the period of enforced adherence to the terms of the last negotiated contract. Act 94 works an impermissible impairment of contractual obligations in violation of the Contract Clause of the Constitution, and amounts to a taking of property without just compensation in violation of the Fourteenth Amendment to the Constitution.

The constitutionally offensive aspect of Act 94 is its retrospective effect. The Act, passed August 2, 1975, applies to any contract then in effect between a member hospital and a hospital plan corporation, or any contract "under which subscribers received prepaid benefits on or after June 30, 1974. . . . Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act." 40 P. S. § 6124(c)2(2). Since the contracts, entered into in 1971, and amended in 1972, contain run-out provisions requiring payment for hospital services rendered after the termination date to subscribers who had been admitted prior to termination, the Act covers contracts which had, in fact, terminated prior to June 30, 1974.

Undoubtedly a state may constitutionally enact legislation imposing conditions on the termination of contracts entered into subsequent to the passage of the legislation, but the state oversteps the bounds when it imposes such conditions upon contracts entered into prior to the adoption of the legislation without providing some measure of protection against loss to the party affected.

Act 94 requires hospitals and the various hospital plan corporations, including Blue Cross, to continue to adhere to the terms of their last negotiated contract for approximately a year beyond the termination date provided in the contract. The effect of the Act is to force contracting hospitals to continue to provide care to subscriber patients at increasing current costs, while reimbursement from the hospital plan corporations is based on previously negotiated cost calculations and formulae which the hospitals claim is insufficient to reimburse them for their expenses.

The cost formulae adopted in the earlier negotiated contracts do not allow to the hospitals, as reimbursable expenses, most community service activities, including care provided to indigents, writing off uncollectible accounts of patients not insured under a contracting hospital plan corporation, providing charity allowances, and undertaking certain education and research activities. Private paying patients or patients with private insurers have, accordingly, always paid a disproportionate share of such expenses. In earlier years there apparently existed sufficient numbers of such patients, and the hospital plan corporation arrangement had sufficient advantages, to make it financially feasible for the hospitals to enter into such agreements. Under the present arrangement, more individuals will likely become subscriber patients because of the relatively lower premiums the hospital plan corporations can charge, since under Act 94 the hospital plan corporations will pay

to the hospitals less than private insurers or self-paying patients will be required to pay. Thus an increasingly higher percentage of the hospitals' patients will not be paying their share of the cost of the hospitals' community service activities. Moreover, subscriber patients will be paying for hospital services, through the hospital plan corporation, rates which do not fully reflect the escalating costs caused by the inflationary spiral. The contracting hospitals have thus been forced by the state into furnishing services at charges lower than their actual expenses of furnishing such services. True, the Act does provide that *if* a new contract is negotiated during the extension period, "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties." *If* a new contract is negotiated between the parties, it would presumably make allowance, satisfactory to the hospitals, for the hospitals' costs of operation. There is no assurance, however, that a new contract which will fairly compensate the hospitals for their costs, *will* be negotiated and entered into, and no provision is made to compensate the hospitals for their losses incurred in the interim period if no new contract is negotiated.

Act 94 clearly has the effect of modifying the contracts that existed between member hospitals and Blue Cross. The majority does not dispute the modifying effect, but finds that the public interest of preserving the health of Pennsylvania citizens justifies the measure. It is true that where the public welfare requires, the state may use its police power in a manner which, to some degree, impairs the obligations of existing contracts, but the states' power to do so is limited. Here the effective excision of the termination clause from the contract is too substantial an impairment, I believe, to be constitutionally permissible. Both parties to the contract bargained for benefits and

burdens they were willing to accept and assume for a certain period of time, subject to their right to terminate at the end of the stated period upon giving 90 days' notice. The excision of that termination provision has the effect of forcing the hospitals to provide, beyond the agreed period, services at charges the hospitals now claim to be below operating cost level, and which are therefore confiscatory.[1]

No matter how great the public need, the state may not, without violating the Fourteenth Amendment, take property without just compensation. The due process and impairment of contract claims are not readily separable, and an impairment claim will usually give rise to a due process claim. *See Fornaris v. Ridge Tool Co.*, 423 F. 2d 563, 566-67 (1st Cir. 1970), *rev'd on other grounds*, 400 U. S. 41 (1971). In the present suit, there is concededly an impairment. I believe the impairment to be so substantial as to violate the Contract Clause, and in any case the impairment works a taking of property without due process of law. The case authority is not to the contrary.

In *Home Building & Loan Association v. Blaisdell*, 290 U. S. 398 (1934), the Supreme Court upheld a state statute which retroactively extended the period during which a defaulting mortgagor could redeem property which had been foreclosed. Although the contract rights of the parties were altered, the Court found the statute constitutionally sound because the substantive rights of the parties were not impaired:

> "The statute does not impair the integrity of the mortgage indebtedness. The obligation for interest remains. The statute does not affect the validity of the sale or the right of the mortgagee-purchaser to title in fee, or his right to obtain a deficiency judgment, if the

1. The affidavits of Messrs. Armstrong, Guest and Williamson may not be sufficient to establish that the imposed rates are confiscatory, but at the very least they raise a material issue of fact for trial.

> mortgagor fails to redeem within the prescribed period. Aside from the extension of time, the other conditions of redemption are unaltered. *While the mortgagor remains in possession he must pay the rental value as that value has been determined, upon notice and hearing, by the court.* The rental value so paid is devoted to the carrying of the property by the application of the required payments to taxes, insurance, and interest on the mortgage indebtedness. While the mortgagee-purchaser is debarred from actual possession, he has, so far as rental value is concerned, the equivalent of possession during the extended period." (Emphasis supplied)

290 U. S. at 425.

Where legislation has been applied retroactively and has altered the substantive contractual rights of the parties, the Supreme Court has invalidated it. In *Louisville Joint Stock Land Bank v. Radford,* 295 U. S. 555 (1935), the Court struck down the Frazier-Lemke Act, a federal law which permitted mortgagors to redeem property at its appraised value, regardless of the amount of the outstanding debt. The Court held that the forced surrender of possession and title to property, so long as any part of the debt secured thereby remained unpaid, effected a taking of property without just compensation and could not be justified, however great the public need. The Court distinguished *Blaisdell, supra,* on the ground that in Blaisdell no substantive right had been abridged. *Id.* at 581. *W. B. Worthen Co. v. Kavanaugh,* 295 U. S. 56 (1935), reaches the same conclusion. In that case the Supreme Court struck down a state statute extending the period of redemption on grounds it violated the Contract Clause. Again the Court found that the substantive rights of the parties had been altered by the legislation in that the

mortgagor was permitted to retain possession of the property without the payment of interest, taxes or rent. In the instant suit, the state has substantially extended the period of the contract and has thereby imposed terms on the hospitals which they claim make it impossible for them to meet their expenses without dipping into reserves. This clearly places the case in line with *Radford* and *Worthen,* and not *Blaisdell.*

Day-Brite Lighting, Inc. v. Missouri, 342 U. S. 421 (1952), is as readily distinguishable as *Blaisdell.* That case involved a state statute which permitted employees to absent themselves from work for several hours, without loss of pay, to vote. In upholding the constitutionality of such legislation, the Supreme Court spoke only of the permissibility of state regulations which impose financial burdens upon, and reduce "the net return" from business enterprises. That is a far cry from the plight of these non profit hospitals which contend they are being required to operate at inadequate and confiscatory levels of reimbursement.

Even if this were regarded as a "rate" case, which I think it clearly is not, "[a]s of right safeguarded by the due process clause of the Fifth Amendment, [the regulated entity] is entitled to rates, not *per se* excessive and extortionate, sufficient to yield a reasonable rate of return upon the value of property used, at the time it is being used, to render the services." *Denver Union Stock Yard v. United States,* 304 U. S. 470, 475 (1938). A *fully* regulated utility cannot be compelled to absorb its own costs and not pass them on to the consumer. *Public Service Commission v. Federal Power Commission,* 467 F. 2d 361, 370 (D. C. Cir. 1972). Even temporary rates which are confiscatory are not permissible. *Prendergast v. New York Telephone Co.,* 262 U. S. 43, 49 (1923). *Cf. Beaver Valley Water Co. v. Driscoll,* 28 F. Supp. 722 (W. D. Pa. 1939).

In the case perhaps most nearly on point, the Court of Appeals for the First Circuit held unconstitutional, as applied to contracts entered into before its passage, a Puerto Rican law which prohibited a manufacturer from terminating a dealership contract unless justified by a substantial failure of performance by the dealer. *Fornaris v. Ridge Tool Co.*, 423 F. 2d 563 (1st Cir. 1970), *rev'd on other grounds*, 400 U. S. 41 (1971). Chief Judge Aldrich based the decision on the Fifth[2] Amendment Due Process Clause, stating that it was unnecessary to deal with the impairment of contracts issue "because the due process clause of the federal constitution provides essentially the same restraint so far as retrospectivity is concerned." He noted that "[i]n determining whether retroactive alteration of contractual provisions are sufficiently minor to be permissible a distinction is sometimes drawn between alteration of substantive rights and alteration of procedures or remedies," and that "[n]o amount of research by parties or amici has discovered a case suggesting that . . ." a statute converting a contractual relationship from one terminable without cause to terminable only for just cause was not one that worked "a change of great magnitude." *Id.* at 567-68 (footnotes omitted). A similar state statute modifying manufacturers' termination rights under franchise agreements was held unconstitutional, this time on the basis of the Contract Clause, in *Superior Motors, Inc. v. Winnebago Industries, Inc.*, 359 F. Supp. 773 (D. S. C. 1973). In my view, the statute in the present case is more egregious than those in *Fornaris* and *Superior Motors* since it prohibits termination altogether during the period of extension.

2. The Fifth, rather than the Fourteenth, Amendment because Puerto Rico is not a state. See generally, discussion in footnotes 7 and 8, *id.* at 566-67.

The Contract Clause is not an absolute barrier to state legislative enactments which have the effect of modifying existing contracts, and there is no question but that a state may regulate enterprises affecting the public interest, but the Constitution sets limits to the manner and degree in which the state may exercise its police power. In the present instance, the failure of the contracting parties to come to an agreement has resulted in an unfortunately hasty reaction by the Pennsylvania legislature which, I believe, exceeds those limits by failing to make provision to protect the hospitals against loss during the period of extension.

Accordingly, I respectfully dissent.

ALFRED L. LUONGO
Alfred L. Luongo

APPENDIX D.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 75-2306

PAUL I. GUEST, et al.

v.

F. EMMETT FITZPATRICK, et al.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES.

Notice is hereby given that Paul I. Guest, et al., the above-named plaintiffs, hereby appeal to the Supreme Court of the United States from the final order denying plaintiffs' motion for summary judgment and granting defendants' motion for summary judgment, entered in this action on February 27, 1976.

This appeal is taken pursuant to 28 U. S. C. § 1253.

JAMES D. CRAWFORD
Attorney for Plaintiffs

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102
Of Counsel.

Dated: March 22, 1976

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 75-2306

PAUL I. GUEST, et al.

v.

F. EMMETT FITZPATRICK, et al.

CERTIFICATE OF SERVICE.

James D. Crawford, attorney for Paul I. Guest, et al., appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certifies that on March 22, 1976 copies of the foregoing Notice of Appeal to the Supreme Court of the United States were served by hand on the several parties thereto by delivery to the offices of their respective counsel as follows:

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Dated: March 22, 1976

Supreme Court, U. S.
FILED
NOV
MICHAEL RODAK, JR., CLERK

APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1691

Paul I. Guest, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

No. 75-1698

Williamsport Hospital, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

Appeals from the United States District Court for the Eastern District of Pennsylvania

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No. 75-1691, Filed May 21, 1976
No. 75-1698, Filed May 24, 1976
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34.	New Jersey Statutes Anno. 26:2H-18	(omitted)
V.	EXHIBITS TO SUPPLEMENTAL AFFIDAVIT OF BRUCE TAYLOR	
35.	American Hospital Association, Principles of Payment for Hospital Care dated September 1953	417a
36.	Financial Statement of Jeanes Hospital as at June 30, 1973	(omitted)
37.	Article re Jeanes Hospital from The Philadelphia Evening Bulletin of September 29, 1961	(omitted)
38.	Schedule of Hospitals Approved for Medicare Participation dated January 1, 1969	(omitted)
39.	Execution Page of Jeanes Hospital—Blue Cross 1971 Hospital Agreement	(omitted)
40.	Correspondence re Interim Rates	441a
41.	Schedule of Basic and Supplement Advances	445a
VI.	EXHIBITS TO SECOND SUPPLEMENTAL AFFIDAVIT OF BRUCE TAYLOR	
42.	Pennsylvania Insurance Department Order and Adjudication dated October 16, 1975	447a
43.	Listing of Hospitals which have Executed the 1974 Agreement	449a
44.	Testimony of Bruce Taylor before the Pennsylvania Insurance Department dated March 17, 1971	450a
45.	40 Federal Register pp. 46202-46203	(omitted)

PAGE

VII. EXHIBITS TO AFFIDAVIT OF JEROME LYNCH

Exhibit

A. Financial Statement of Taylor Hospital as at June 30, 1975..... (omitted)

B. Financial Statement of Sacred Heart Hospital— Norristown as at June 30, 1974..... (omitted)

C. Financial Statement of Doylestown Hospital as at June 30, 1974..... (omitted)

D. Financial Statement of Sacred Heart General Hospital as at June 30, 1974..... (omitted)

E. Financial Statement of Riddle Memorial Hospital as at June 30, 1974..... (omitted)

F. Financial Statement of Wills Eye Hospital as at June 30, 1974..... (omitted)

G. Financial Statement of Paoli Memorial Hospital as at June 30, 1975..... (omitted)

H. Financial Statement of Delaware County Memorial Hospital as at June 30, 1974..... (omitted)

I. Correspondence and Memorandum re Mercy Catholic Medical Center Medicare Cost Audit..... (omitted)

J. Financial Statement of Presbyterian-University of Pennsylvania Medical Center as at June 30, 1975..... (omitted)

K. Memorandum and Letter from Cost Manager of Presbyterian-University of Pennsylvania Medical Center..... (omitted)

L. Letter from Controller of Presbyterian-University of Pennsylvania Medical Center..... (omitted)

RELEVANT DOCKET ENTRIES

	1975		
1	Aug. 11		Complaint, filed.
1	Aug. 11		Summons exit.
2	Aug. 14		Deft. Blue Cross of Greater Phila's notice of deposition of Plff., filed.
3	Aug. 25		Appearance of Bonnie Brigance Leadbetter, Asst. District Attorney, for Deft. F. Emmett Fitzpatrick, filed.
4	Aug. 27		Appearance of Howard M. Holmes, Asst. Attorney General, for Deft. Robert P. Kane, filed.
5	Sept.	3	Report of Pretrial Conference, Weiner, J., filed.
6	Sept.	3	Answer of Deft. F. Emmett Fitzpatrick, filed.
—	Sept.	3	CASE LISTED FOR TRIAL
7	Sept.	12	Plffs' Motion to add Defts.; Motion of Williamsport Hospital, et al, to Intervene as Plffs.; Memorandum in support thereof; and Certificate of Service, filed.
7	Sept.	25	Order dtd 9/19/75 that the Insurance Dept. of the Commonwealth of Pa. be made party Deft., etc.; that Williamsport Hospital, Delaware Valley Hospital Council, and Hospital Association of Penna. have leave to INTERVENE, etc., filed. 9/26/75 entered and copies mailed. CW
	Sept.	25	Amended Complaint, filed.
8	Sept.	25	Stipulation and Order dtd 9/19/75 WITHDRAWING request for temporary restraining order, without prejudice; counsel for Deft. Fitzpatrick is excused from participa-

tion in any hearings & arguments, etc.; extending time to 10/2/75 for Defts. to answer, etc.; that parties anticipate convening Three-Judge Court, and fixing hearing and argument on cross-Motions for Summary Judgment for 10/14/75, etc., filed.
CW

9 Oct. 3 Order dtd 9/30/75 designating VanDusen, J., U.S. Circuit Judge, and Luongo, J., to sit with Weiner, J., as members of the Court for hearing and determination of this matter, filed.
10/7/75 entered and copies mailed.
(including Gov. and Attorney Gen.)
Seitz, Ch.J.

10 Oct. 7 Answer of Defts. Blue Cross of Greater Phila., Robert P. Kane, and Insurance Dept. of the Commonwealth of Pa. to Amended Complaint, filed.

11 Oct. 7 Plffs. and Plffs-Intervenors' Motion for Summary Judgment, Memorandum in support thereof, and Certificate of Service, filed.

12 Oct. 7 Joint Motion of Defts. Blue Cross of Greater Phila., Robert Kane, and Insurance Dept. of Commonwealth of Pa., for Summary Judgment, and Brief in support thereof, filed.

13-16 Oct 7 Affidavit of Bruce Taylor, President, Blue Cross of Greater Phila., with accompanying exhibits), filed. (4 Vols.)

17 Oct. 14 Supplemental Affidavit of Bruce Taylor, President, Blue Cross of Greater Phila., with accompanying exhibits, filed.

— Oct. 14 Argued sur Cross-Motions for Summary Judgment, C.A.V.
CW

18 Oct. 29 Supplemental Affidavits of Paul I. Guest and Joseph A. Williamson with attachments, filed.

19 Nov. 17 Supplemental Memorandum & Affidavits of Bruce Taylor & Jerome Lynch, with Accompanying Exhibits, filed.

1976

20 Feb. 27 Opinion, Van Dusen, C.J., and Weiner, J.; Dissenting Opinion, Luongo, J.; and Order that Plffs' motion for Summary Judgment is DENIED; Defts' motions for Summary Judgment are GRANTED, filed.
3/2/76 entered and copies mailed.
(incl. Gov. & Att. General)
VanDusen
CW & AL

21 Mar. 22 Notice of Appeal of Plffs., filed.
3/23/76 entered and copies mailed. USCA, counsel, Gov. & Att.

22 Mar. 22 Copy of Clerk's Notice to U.S. Court of Appeals, filed
3/23/76 entered and copy to VanDusen, C. J., Luongo, J., and Weiner, J.

23 Mar. 22 Plffs' Notice of Appeal to the Supreme Court of the United States, filed.

24 Mar. 26 Plffs. Williamsport Hospital and the Hospital Association of Penna.'s Notice of Appeal to the Supreme Court of the United States, filed.

— Apr. 13 Record on appeal transmitted to U.S. Court of Appeals.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No.

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of ST. JOSEPH's HOSPITAL; and METHODIST HOSPITAL, on behalf of themselves and all others similarly situated,

Plaintiffs

v.

EMMETT F. FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in their Official Capacities, and BLUE CROSS of GREATER PHILADELPHIA,

Defendants

COMPLAINT—CLASS ACTION

Parties

1. Plaintiff Paul I. Guest, is the president of plaintiff Methodist Hospital, located at 2301 South Broad Street, Philadelphia, Pennsylvania, 19148; plaintiff, Charles H. Frenzel is the executive vice president of Mercy Catholic Medical Center which includes its Misericordia Hospital Division located at 54th Street and Cedar Avenue, Philadelphia, Pennsylvania 19143; plaintiff Philip J. Sawlinsky is the manager of patient accounts at St. Joseph's Hospital located at 16th Street and Girard Avenue, Philadelphia, Pennsylvania 19130; and plaintiff Methodist Hospital is a non-profit corporation organized under the laws of Pennsylvania and located at 2301 South Broad Street,

Philadelphia, Pennsylvania, 19148. All hospitals which are members of the plaintiff class herein are eligible hospitals within the meaning of Section 6121 of Title 40 of the Pennsylvania Consolidated Statutes, 40 Pa. C.S. § 6121, and all executive officers, administrators and employees who are members of the plaintiff class are attached to such hospitals. Together the hospitals in the class have more than 5% of the beds in an area served by defendant Blue Cross of Greater Philadelphia, a hospital plan corporation within the meaning of § 6102 of that Title 40.

2. Defendant Emmett F. Fitzpatrick, Jr. ("Fitzpatrick") is the District Attorney of Philadelphia, Pennsylvania. Defendant Robert P. Kane ("Kane") is Attorney General of the Commonwealth of Pennsylvania. Each has responsibility for the enforcement of Act No. 94, ("the Act"), Act of August 2, 1975, amending § 6124 of Title 40 of the Pennsylvania Consolidated Statutes, which provides, *inter alia,* a procedure whereby the termination of all existing and future contracts, as well as certain terminated contracts, between eligible hospitals and hospital plan corporations are to be subject to ninety days notice and to prior approval by the Insurance Department which is authorized to suspend termination of such contracts for a period of almost ten additional months pending its approval. They are sued individually and in their official capacities. Defendant Blue Cross of Greater Philadelphia ("Blue Cross") is a non-profit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal office and place of business at 1333 Chestnut Street, Philadelphia, Pennsylvania 19107. Defendant Blue Cross is an insurance company whose primary business is the sale of health care insurance to individuals and groups in Southeastern Pennsylvania. As such, it is a hospital plan corporation within the meaning of 40 Pa. C.S. § 6102.

Nature of Action

3. This is an action for a declaratory judgment and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202. The action arises from an actual controversy between plaintiffs and defendants as hereinafter fully appears. Plaintiffs seek a declaration that the retroactive application of the Act to a now terminated contract previously in force between plaintiff hospital and hospitals in the class and defendant Blue Cross is repugnant to the Constitution of the United States, specifically the Contract Clause, Article I, Section 1, Clause 10, and the Due Process Clause of the Fourteenth Amendment. An injunction against defendants Fitzpatrick and Kane is sought to prevent enforcement of the Act by means of the criminal penalties provided at Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes, which, by its terms, would expose all plaintiffs and other members of the class of hospitals and hospital executive officers, administrators and employees which they seek to represent, to criminal penalties upon any violation of the Act. A further injunction is sought against defendant Blue Cross to prevent enforcement of the terminated contract.

Jurisdiction

4. This Court has jurisdiction over this matter under 28 U.S.C. § 1331 since the action arises under the Constitution of the United States as set forth above in paragraph 3 of this Complaint and the amount in controversy exceeds the sum of Ten Thousand Dollars ($10,000) exclusive of interest and costs, and under 28 U.S.C. §1343(3) because the action arises under the Constitution of the United States, specifically the Due Process Clause of the Fourteenth Amendment and the Contract Clause.

5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since

plaintiffs seek an injunction to restrain the enforcement, operation and execution of a statute of the Commonwealth of Pennsylvania, which has statewide application, on the grounds that said statute is violative of the United States' Constitution.

Operative Facts

6. The Act, entitled "An Act Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing the Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships," amends Section 6124 of Title 40 by the addition of a subsection (c) which provides that ". . . termination of contracts between hospital plan corporations [here defendant Blue Cross] and hospitals entered into pursuant to Section 6121 (relating to eligible hospitals) and this Section to be subject to prior approval by the department as provided in this subsection."

A procedure is thereafter prescribed at subparagraphs (2), (3) and (4) whereby ninety days notice of termination is required and the Insurance Department is empowered to suspend the termination of such contracts, provided the hospitals involved have more than 5% of the beds in an area served by a hospital plan corporation, for a period of almost ten months thereafter, during which time the parties are to continue to be bound by all terms and conditions of the contract sought to be terminated.

7. Section 2 of the Act provides that the above procedure shall apply not only prospectively to the termination of future covered contracts but also retroactively to "any contracts between hospital plan corporations and

hospitals under which subscribers received prepaid benefits on or after June 30, 1974, if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C.S. Chap. 61 (relating to Hospital Plan Corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. *Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.*" (Emphasis supplied).

Section 3 of the Act expressly provides that "[t]his act shall take effect immediately and *shall be retroactive to the extent provided in Section 2 hereof.*" (Emphasis supplied).

8. The Delaware Valley Hospital Council, on behalf of plaintiff hospital and others of the class which it represents, and defendant Blue Cross adopted a contract, approved by the Insurance Department in accordance with 40 Pa. C.S. § 6124, under which defendant Blue Cross as insurer paid plaintiff hospital and others in its class ("provider hospitals") an agreed portion but less than all of the hospitals' actual cost of providing treatment for Blue Cross subscribers. This contract, as modified and extended by a "Summary of Principles to be Utilized in Drafting an Interim 1973 Hospital Agreement" (which 1973 Agreement was never successfully negotiated), terminated by its terms on June 30, 1974, and, subject to certain "run out" provisions providing for the orderly termination of coverage to individual subscribers,* defend-

* Pursuant to a Settlement Agreement reached in *Crozer Chester Medical Center, et al.* v. *Blue Cross of Greater Philadelphia,* No. 9799, 1974 Term (C.P. Del. Co. September 25, 1974), the "run out" provisions of the original contract as modified by the Summary of Principles went into effect on August 15, 1974. During this "run out" period, subscribers' coverages have terminated, each on its anniversary date, so that all coverage for all subscribers will have ceased as of August 15, 1975 but for the application of Act No. 94.

ant Blue Cross ceased to pay the hospitals directly pursuant to the terminated contract, but the patient-subscribers gradually became billable directly by the hospitals for the *full* costs of their hospitalization and treatment, just as are nonsubscriber private paying patients.

Class Action Allegations

9. The present action is brought by the named plaintiffs on their own behalf and as representatives of a class, as defined in Rule 23 of the Federal Rules of Civil Procedure, comprised of all hospitals which were signatories to the Summary of Principles with defendant Blue Cross, which contract had lawfully terminated as of June 30, 1974, and which contract is now reinstated by the express provisions of the Act, and all executives, administrators, and employees of those hospitals responsible for the billing of patients, directly or indirectly, all of whom are liable to criminal prosecution under Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes in the event of a failure to comply with the terms of the reinstated contract in accordance with the provisions of the Act. The members of the class are, likewise, directly involved in the application of the reinstated contract between defendant Blue Cross and plaintiff hospital class. The members of the class are so numerous as to make it impracticable to bring them before the Court. The questions of law and fact common to the class predominate over any question affecting individual members only. The claims of the representative plaintiffs are typical—if not identical—to the claims of the sub-class represented by each, and plaintiffs will fairly and adequately protect the interests of the class.

10. The prosecution of separate actions by individual members of the class would create the risk of:

(a) inconsistent or varying adjudications with respect to individual members of the class; and

(b) adjudications with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of the members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

COUNT I

(All Defendants)

11. Paragraphs 1 through 10 of this Complaint are incorporated herein by reference.

12. Under the express provisions of Section 2(2) of the Act, the contract between defendant Blue Cross and plaintiff hospital class, terminated over a year ago, is reinstated as of its original termination date and, under the provisions of Section 1 of the Act, may not now be terminated without ninety days notice and without the consent of the Insurance Department for a period of up to ten months thereafter, all from the effective date of the Act.

13. The effect of the application of the Act to the above contract would be to destroy the plaintiff hospitals' legal right to full payment for services rendered Blue Cross subscribers, a right previously modified by agreement and restored, pending compliance with the "run out" provisions, when the contract embodying that agreement terminated on June 30, 1974. Thus, for the elapsed one year period since the "run out" provisions went into effect and for up to thirteen months hence, the hospitals in plaintiff class will be required to accept partial payment for services for which they are entitled to full payment.

14. Under the terms of the contract imposed upon the plaintiff hospital class by governmental action, the hospitals cannot recover their legitimate costs of supplying services and facilities to Blue Cross subscribers for the period from the time the contract lawfully terminated through the time that termination is to be deemed finally effective. This constitutes a governmental taking of property without just compensation condemned by the Due Process Clause. *Louisville Joint Stock Land Bank* v. *Radford,* 295 U.S. 555 (1935); *Fornaris* v. *Ridge Tool Co.,* 423 F.2d 563 (1st Cir.), *rev'd on other grounds* 400 U.S. 41 (1970). Even with respect to public utilities, a state legislature has no power to impose contracts requiring the provision of service at confiscatory rates, like those imposed here, which do not permit a recovery of costs. *Prendergast* v. *New York Telephone Co.,* 262 U.S. 43 (1923).

15. Retroactive application of the Act to reinstate a contract already terminated without protection of the substantial rights thereby affected, constitutes an impairment of contract prohibited by the Contract Clause. This is true regardless of the alleged public interest involved. *W.B. Worthen Co.* v. *Kavanagh,* 295 U.S. 56 (1935). *See Superior Motors, Inc.* v. *Winnebago Inds., Inc.,* 259 F. Supp. 773 (D.S.C. 1973).

16. Accordingly, both the Due Process and Contract Clauses prohibit retroactive application of the Act to a contract which had been lawfully terminated prior to its passage, where the effect of such application would be to impose upon plaintiff hospitals a contractual obligation which would not otherwise exist, to render service at a confiscatory rate which will not permit them to recover the legitimate costs of providing that service.

COUNT II

(Defendants Fitzpatrick and Kane)

17. Paragraphs 1 through 16 of this Complaint are incorporated herein by reference.

18. Section 6105 of Title 40 prescribes criminal penalties against any person or legal entity violating any provision of that Chapter or any regulations or orders of the Insurance Department made pursuant thereto, which Section is applicable to provisions of the Act amending 40 Pa. C.S. § 6124.

19. Having determined that the Act is unconstitutional for the reasons set forth above at paragraphs 13 through 16 of this Complaint, members of plaintiff class are now confronted with an insoluable trilemma: they are barred by the Act, upon pain of criminal prosecution under § 6105, from attempting to recover their costs, *inter alia,* by direct billing of patient-subscribers; they cannot bill defendant Blue Cross for the portion of their costs recoverable under the contract without risk of being estopped from pressing their constitutional challenge to the Act, *see, e.g., Wall* v. *Parrott Silver & Copper Co.,* 244 U.S. 407 (1917); and they are clearly not in a financial position simply to absorb the costs associated with treating Blue Cross subscribers—who constitute more than a third of the patient population of plaintiff hospitals—without billing either defendant Blue Cross or its subscribers pending the determination of this suit.

20. Unless plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable injury, being forced either to sacrifice a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to expose themselves to criminal penalties in order to preserve their constitutional challenge.

21. Unless plaintiffs are granted injunctive relief the public will suffer irreparable injury since non-profit hospitals cannot be forced to provide service to one-third

of their patients at confiscatory rates without adversely affecting their service to the general public from whom their patient population is drawn.

22. The granting of a preliminary injunction will in no way harm defendants or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from plaintiff hospitals—including Blue Cross subscribers—must be responsible for the hospitals' legitimate costs of rendering these services.

COUNT III

(Defendant Blue Cross)

23. Paragraphs 1 through 16 of this Complaint are incorporated herein by reference.

24. On August 5, 1975, defendant Blue Cross, without consulting with the Insurance Department of the Commonwealth of Pennsylvania or with representatives of plaintiff hospital class, sent out a letter to the chief executive officers of the hospitals represented by Delaware Valley Hospital Council ("DVHC") announcing that defendant Blue Cross would hereafter make payments under the terminated contract reinstated by Act No. 94. That letter stated that "[b]y your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases . . . notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases." The letter further provided that each check would contain a restrictive endorsement incorporating this "understanding." A copy of the letter is attached hereto as Exhibit A.

25. On August 8, 1975, representatives of defendant Blue Cross and of plaintiff hospital class, including plain-

tiff Guest, met under the auspices of the Commissioner of the Insurance Department of the Commonwealth of Pennsylvania to discuss the orderly implementation of Act No. 94 and the way in which its constitutionality could be challenged in the least disruptive manner. The representatives of defendant Blue Cross refused to participate in the meeting and walked out of it.

26. On August 11, 1975, defendant Blue Cross without consulting with DVHC or its member hospitals whose names were listed on the advertisement, caused a full page advertisement to be placed in the Philadelphia Inquirer which announced that "your Blue Cross card will be accepted by all member hospitals [of DVHC] as of August 2, 1975." The advertisement further stated that subscribers who were billed by hospitals represented by DVHC during the period after the termination of the agreement between member hospitals and defendant Blue Cross are no longer liable for the full costs of their treatment and that those who paid that full cost should receive refunds from the hospitals. A copy of the advertisement is attached hereto as Exhibit B.

27. Paragraph 19 of this Complaint is incorporated herein by reference.

28. By means of the procedure outlined in the letter of August 5, 1975, defendant Blue Cross has sought to prevent plaintiff hospital class from recovering the full costs of services provided by these hospitals even if Act No. 94 is determined to be unconstitutional. By refusing to negotiate in the presence of the Insurance Commissioner and by placing its advertisement in the August 11, 1975 Philadelphia Inquirer, defendant Blue Cross has sought to force plaintiff hospital class to accept Act No. 94 whether or not it is constitutional, and has sought to prevent the development of an orderly procedure for

testing the constitutionality of that Act without requiring that the members of plaintiff hospital class accept less than full compensation for services provided Blue Cross subscribers even if the Act is determined to be unconstitutional.

29. Unless plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable injury, being forced either to sacrifice the benefits of a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to receive no payments from defendant Blue Cross for services rendered to Blue Cross subscribers during the period in which they litigate this challenge.

30. Paragraph 21 of this Complaint is incorporated herein by reference.

31. The granting of a preliminary injunction will in no way harm defendant Blue Cross or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from plaintiff hospitals—including Blue Cross subscribers—must be responsible for the hospitals' legitimate cost of rendering those services.

WHEREFORE, plaintiffs pray that this Court:

(1) issue an order temporarily restraining defendants Fitzpatrick and Kane from enforcing the criminal penalties for violating Act No. 94;

(2) issue an order temporarily restraining defendant Blue Cross from requiring plaintiff hospital class to waive the benefits of a determination that Act No. 94 is unconstitutional;

(3) issue an order convening a three-judge district court as required by 28 U.S.C. §§ 2281 and 2284;

(4) advance this action on the docket and order a speedy hearing of this action according to law, and upon such hearing enter an order;

(a) declaring Act No. 94 unconstitutional as applied retroactively to reinstate a contract terminated before passage of the Act and to impose upon hospitals in plaintiff class a duty to provide services at a confiscatory rate of payment;

(b) enjoining preliminary pending final resolution of this action, and permanently thereafter, enforcement and application of the Act insofar as it impairs plaintiff hospitals' legal right to recover the full cost of hospitalization and services rendered by them to patients; and

(c) granting such other and further relief as may be appropriate in the circumstances.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL
Attorneys for Plaintiff

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

Dated: August 11, 1975

EXHIBIT A

BLUE CROSS OF GREATER PHILADELPHIA

August 5, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

On August 2, 1975, Governor Shapp signed into law Act No. 94 which requires that contractual relationships between hospitals and non-profit hospital plan corporations may only be terminated pursuant to that legislation. Accordingly, since the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement"), has not been so terminated, we will immediately move to take such administrative action as is necessary and appropriate in light of the reinstatement of the Agreement.

In that regard, it is requested that you immediately file your fiscal 1975-1976 budgets on the approved forms as required by Section 18 of the Agreement. Upon receipt of this information we will undertake the budgetary review process and thereafter establish, as appropriate, revised inpatient interim per diem rates. Furthermore, we are reviewing all Blue Cross cases which were previously paid on a non-member indemnity basis directly to Subscribers. At such time as this process has been completed, we will promulgate the administrative procedures we propose to follow in making any required retroactive payment, including restoration of the advances contemplated by the 1973 Summary of Principles.

Commencing immediately Blue Cross will make daily payments to all hospitals pursuant to the Agreement for Covered Services rendered Subscribers on a current basis.

These payments shall be based on the present interim inpatient per diem rates, which amounts will be adjusted when the budgetary information requested above has been received and approved. By your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases, both inpatient and outpatient, subject only to the adjustments required by the Agreement, notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases. Moreover, each check representing such payment shall contain a restrictive endorsement indicating that such is made pursuant to this understanding and represents your full concurrence thereto. This policy is being adopted to eliminate any question as to the obligation of Blue Cross to make duplicate payments to the Provider and Subscriber for the same Covered Services.

The teletype confirmations which Blue Cross provides hospitals in response to inquires as to a given Subscriber's benefits shall, for the remainder of this month, indicate by the addition of a double asterisk (**) after their name those individuals who would have been entitled to member benefits without Act No. 94. This identification procedure is intended to quickly identify such cases for your continuing records.

If after reviewing the foregoing you have any question as to the methodology or procedure that Blue Cross intends to follow, please feel free to contact our offices.

Very truly yours,

/s/ Howard W. Baker, M.D.

Howard W. Baker, M.D.
Vice President

HWB: ccb

EXHIBIT B

(Copy of advertisement in August 11, 1975, edition of The Philadelphia Inquirer, placed by Blue Cross of Greater Philadelphia—omitted)

(Affidavit omitted in printing)

(Title omitted in printing)

ORDER FOR HEARINGS ON PRELIMINARY INJUNCTION AND TEMPORARY RESTRAINING ORDER

And Now, this day of August, 1975, upon presentation and consideration of plaintiffs' verified Complaint requesting a preliminary injunction,

It Is Hereby Ordered that plaintiffs' Motion for a Preliminary Injunction be, and the same hereby is, set for hearing before a Three-Judge district court on the day of , 1975, at M. in Room in the United States District Court for the Eastern District of Pennsylvania and that a copy of this Order be served immediately, together with a copy of the summons and complaint, upon the defendants and due return be made according to law.

And It Is Further Ordered that, since defendants are about to commit the acts sought to be preliminarily enjoined and immediate and irreparable harm will thereby result to plaintiffs before hearing can be held on a preliminary injunction, immediate hearing will be held on the attached temporary restraining orders.

J.

(Title omitted in printing)

TEMPORARY RESTRAINING ORDER
(Defendants Fitzpatrick and Kane)

This matter having come on to be heard upon plaintiffs' motion for a temporary restraining order, supported by a verified Complaint, and it appearing to the Court that plaintiffs and the class they represent and the general public will suffer immediate and irreparable harm if before their motion for preliminary injunction can be heard, they are forced either to risk criminal penalties by attempting to recover the full costs of providing service to Blue Cross subscribers, or to waive their constitutional challenge to Act 94 by claiming partial payment under the contract imposed upon them by the Act, or to defer any attempt to recover these costs and risk insolvency before their claims are finally resolved; and counsel for defendants Fitzpatrick and Kane having been given notice of this application and opportunity to state why it should not be granted; and it further appearing that none of the defendants nor the public will suffer immediate and irreparable harm as a result of the issuance of a temporary restraining order designed to preserve the status quo pending the hearing on plaintiffs' motion for a preliminary injunction;

It Is Ordered that defendants Fitzpatrick and Kane, the officers, servants and employees and all other persons in active concert or participation with them be, and they are hereby, temporarily restrained from enforcing against plaintiffs the penal provisions contained at Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes.

It Is Further Ordered that the foregoing order shall expire on , 1975, unless it is further ex-

tended by order of the Court or unless defendants Fitzpatrick and Kane consent that it may be extended for a longer period.

It Is Further Ordered that plaintiffs file their bond, with corporate surety, in the sum of , conditioned for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined.

_____

J.

(Title omitted in printing)

TEMPORARY RESTRAINING ORDER
(Defendant Blue Cross)

This matter having come on to be heard upon plaintiffs' motion for a temporary restraining order, supported by a verified Complaint, and it appearing to the Court that plaintiffs and the class they represent and the general public will suffer immediate and irreparable harm if before their motion for preliminary injunction can be heard, they are compelled by unilateral action of defendant Blue Cross to accept payment in accordance with the terms of the contract "reinstated" by Act No. 94 on condition that they waive any right to full compensation for services rendered Blue Cross subscribers, even if Act No. 94 is determined to be unconstitutional; and counsel for defendant Blue Cross having been given notice of this application and opportunity to state why it should not be granted; and it further appearing that none of the defendants nor the public will suffer immediate and irreparable harm as a result of the issuanuce of a temporary re-

straining order designed to preserve the status quo pending the hearing on plaintiffs' motion for a preliminary injunction;

IT IS ORDERED that defendant Blue Cross, its officers, servants and employees and all other persons in active concert or participation with it be, and they are hereby, temporarily restrained from unilaterally requiring plaintiffs to accept payment in accordance with the terms of the contract "reinstated" by Act No. 94 on condition that they waive any right to full payment for services rendered Blue Cross subscribers even if Act No. 94 is held to be unconstitutional.

IT IS FURTHER ORDERED that the foregoing order shall expire on , 1975, unless it is further extended by order of the Court or unless defendant Blue Cross consents that it may be extended for a longer period.

IT IS FURTHER ORDERED that plaintiffs file their bond, with corporate surety, in the sum of , conditioned for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined.

J.

(Certificate of service omitted in printing)

(title omitted in printing)

STIPULATION

It is hereby stipulated between plaintiffs, by their counsel James D. Crawford, and defendant F. Emmett Fitzpatrick, Jr., by his counsel Bonnie Brigance Leadbetter, defendant Robert P. Kane, by his counsel Howard Holmes, and defendant Blue Cross of Greater Philadelphia, by its counsel Denis Brenan, with the approval of the Court, that:

1. In the light of the agreement of defendants Fitzpatrick and Kane, by their counsel, not to seek criminal sanctions for acts committed by members of the class represented by plaintiffs which might be in violation of Act No. 94 while that Act remains subject to constitutional challenge, the request for a temporary restraining order against defendants Fitzpatrick and Kane is withdrawn without prejudice;

2. In the light of the exchange of correspondence between Howard W. Baker, M.D., Vice President of Blue Cross of Greater Phiadelphia, and the Chief Executive Officers of DVHC represented hospitals on August 5, 20, 21 and 26, between Frank H. Abbott, counsel for the DVHC represented hospitals, and William Zeiter, counsel for Blue Cross of Greater Philadelphia, on August 21, 1975, and Mr. Zeiter's reply on August 22 and the letter of Mr. Abbott to Mr. Taylor on August 27, 1975 and Mr. Taylor's reply of the same date, the request for a temporary restraining order against defendant Blue Cross is hereby withdrawn without prejudice;

3. Counsel for defendant Fitzpatrick is excused from participation in any hearings or arguments in this case for the reasons set forth in the answer of defendant F. Emmett Fitzpatrick but will be served copies of all papers filed in the case and will receive notice of all hearings and arguments therein;

4. If plaintiffs or others represented by counsel for plaintiffs wish to file an amended complaint or a motion to intervene as plaintiffs, the amended complaint or motion to intervene will be filed on or before September 10, 1975;

5. The time within which defendants must answer, move or otherwise plead to the original complaint in this case or to any amended complaint or motion to intervene is extended to October 2, 1975;

6. Plaintiffs, including any additional plaintiffs, and defendants Kane and Blue Cross will prepare cross motions for summary judgment with supporting affidavits and memoranda in support thereof and will file and serve the motions, affidavits and memoranda upon the Court and parties on or before October 2, 1975; and

7. The parties anticipate that a three-judge court will be convened, there being no opposition to this request on behalf of defendants, and that a hearing and argument on the cross motions for summary judgment will be scheduled before that Court on October 13, 1975 or such other time as the Court finds appropriate.

/s/ JAMES D. CRAWFORD

JAMES D. CRAWFORD
FRANK H. ABBOTT
SCHNADER, HARRISON, SEGAL & LEWIS

Counsel for Plaintiffs
Paul I. Guest, President of Methodist Hospital; Charles H. Frenzel, Executive Vice President of Mercy Catholic Medical Center; Philip J. Sawlinsky, Manager of Patient Accounts of St. Joseph's Hospital; and Methodist Hospital

/s/ BONNIE BRIGANCE LEADBETTER

BONNIE BRIGANCE LEADBETTER
Assistant District Attorney

Counsel for Defendant
F. Emmett Fitzpatrick, Jr.
District Attorney of Philadelphia

/s/ HOWARD HOLMES

HOWARD HOLMES
Assistant Attorney General

Counsel for Defendant
Robert P. Kane, Attorney General of the Commonwealth of Pennsylvania

/s/ DENIS BRENAN

DENIS BRENAN

Counsel for Defendant
Blue Cross of Greater Philadelphia

The foregoing stipulation is approved by the Court this 19th day of September, 1975.

/s/ CHARLES R. WEINER

J.

(title omitted in printing)

AMENDED COMPLAINT,
MOTION TO INTERVENE AS PLAINTIFFS,
MOTION BY PLAINTIFFS TO ADD DEFENDANT,
MEMORANDUM OF LAW,
ORDER, AND
CERTIFICATE OF SERVICE

AMENDED COMPLAINT—CLASS ACTION

Parties

1. Plaintiff Paul I. Guest, is the president of plaintiff Methodist Hospital, located at 2301 South Broad Street, Philadelphia, Pennsylvania, 19148; plaintiff, Charles H. Frenzel is the executive vice president of Mercy Catholic Medical Center which includes its Misericordia Hospital Division located at 54th Street and Cedar Avenue, Philadelphia, Pennsylvania 19143; plaintiff Philip J. Sawlinsky is the manager of patient accounts at St. Joseph's Hospital located at 16th Street and Girard Avenue, Philadelphia, Pennsylvania 19130; and plaintiff Methodist Hospital is a non-profit corporation organized under the laws of Pennsylvania and located at 2301 South Broad Street, Philadelphia, Pennsylvania, 19148. Plaintiff-intervenor Williamsport Hospital is a non-profit corporation organized under the laws of Pennsylvania and located at 777 Rural Avenue, Williamsport, Pennsylvania, 17701; plaintiff-intervenor Delaware Valley Hospital Council ("DVHC") is a non-profit corporation organized under the laws of Pennsylvania and located at 311 South Juniper Street, Philadelphia, Pennsylvania, 19107; and plaintiff-intervenor Hospital Assocation of Pennsylvania ("HAP") is a non-profit corporation organized under the laws of Pennsylvania and located at

1200 Camp Hill Bypass, Camp Hill, Pennsylvania, 17011. All hospitals which are members of the plaintiff class herein are eligible hospitals within the meaning of Section 6121 of Title 40 of the Pennsylvania Consolidated Statutes, 40 Pa. C.S. § 6121, and all executive officers, administrators and employees who are members of the plaintiff class are attached to such hospitals. DVHC and HAP are organizations whose members are also members of the plaintiff hospital class within their respective geographic areas. Together the hospitals in the class located in the Delaware Valley have more than 5% of the beds in an area served by defendant Blue Cross of Greater Philadelphia, a hospital plan corporation within the meaning of § 6102 of that Title 40, and the hospitals on the class located in Northeastern Pennsylvania have more than 5% of the beds in the area served by Hospital Services Association of Northeastern Pennsylvania, a hospital plan corporation within the meaning of § 6102 of that Title 40.

2. Defendant F. Emmett Fitzpatrick ("Fitzpatrick") is the District Attorney of Philadelphia, Pennsylvania. Defendant Robert P. Kane ("Kane") is Attorney General of the Commonwealth of Pennsylvania. Defendant the Insurance Department of Pennsylvania ("Insurance Department") is a department of the Commonwealth of Pennsylvania established by the Act of May 17, 1921, P.L. 789, § 201, 40 P.S. § 41. Each has responsibility for the enforcement of Act No. 94, ("the Act"), Act of August 2, 1975, amending § 6124 of Title 40 of the Pennsylvania Consolidated Statutes, which provides, *inter alia,* a procedure whereby the termination of all existing and future contracts, as well as certain terminated contracts, between eligible hospitals and hospital plan corporations are to be subject to ninety days notice and to prior approval by defendant Insurance Department which is authorized to

suspend termination of such contracts for a period of almost ten additional months pending its approval. Defendants Fitzpatrick and Kane are sued individually and in their official capacities. Defendant Blue Cross of Greater Philadelphia ("Blue Cross') is a non-profit corporation organized and existing under the laws of the Commonwealth of Pennsylvania with its principal office and place of business at 1333 Chestnut Street, Philadelphia, Pennsylvania 19107. Defendant Blue Cross is an insurance company whose primary business is the sale of health care insurance to individuals and groups in Southeastern Pennsylvania. As such, it is a hospital plan corporation within the meaning of 40 Pa. C.S. § 6102.

Nature of Action

3. This is an action for a declaratory judgment and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202. The action arises from an actual controversy between plaintiffs and plaintiffs-intervenors ("plaintiffs") on the one hand and defendants on the other as hereinafter fully appears. Plaintiffs seek a declaration that the application of the Act to contracts between plaintiff hospitals and hospitals in the class and various hospital plan corporations including defendant Blue Cross is repugnant to the Constitution of the United States, specifically the Contract Clause, Article I, Section 1, Clause 10, and the Due Process Clause of the Fourteenth Amendment. An injunction against defendants Fitzpatrick and Kane is sought to prevent enforcement of the Act by means of the criminal penalties provided at Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes, which, by its terms, would expose all plaintiffs and other members of the class of hospitals and hospital executive officers, administrators and employees which they seek to represent, to criminal penalties upon any violation of the Act. An

injunction against defendant Insurance Department is sought to prevent administrative execution and enforcement of the Act. A further injunction is sought against defendant Blue Cross to prevent enforcement of the terminated contract.

Jurisdiction

4. This Court has jurisdiction over this matter under 28 U.S.C. § 1331 since the action arises under the Constitution of the United States as set forth above in paragraph 3 of this Complaint and the amount in controversy exceeds the sum of Ten Thousand Dollars ($10,000) exclusive of interest and costs, and under 28 U.S.C. § 1343(3) because the action arises under the Constitution of the United States, specifically the Due Process Clause of the Fourteenth Amendment and the Contract Clause.

5. This is a proper case for determination by a three-judge court pursuant to 28 U.S.C. §§ 2281 and 2284 since plaintiffs seek an injunction to restrain the enforcement, operation and execution of a statute of the Commonwealth of Pennsylvania, which has statewide application, on the grounds that said statute is violative of the United States Constitution.

Operative Facts

6. The Act, entitled "An Act Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing defendant Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships," amends Section 6124 of Title

40 by the addition of a subsection (c) which provides that ". . . termination of contracts between hospital plan corporations [here including defendant Blue Cross] and hospitals entered into pursuant to Section 6121 (relating to eligible hospitals) and this Section to be subject to prior approval by the Insurance Department as provided in this subsection."

A procedure is thereafter prescribed at subparagraphs (2), (3) and (4) whereby ninety days notice of termination is required and additional defendant Insurance Department is empowered to suspend the termination of such contracts, provided the hospitals involved have more than 5% of the beds in an area served by a hospital plan corporation, for a period of almost ten months thereafter, during which time the parties are to continue to be bound by all terms and conditions of the contract sought to be terminated.

7. Section 2 of the Act provides that the above procedure shall apply not only prospectively to the termination of covered contracts entered into in the future but also retroactively to both existing contracts and to "any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974, if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C.S. Chap. 61 (relating to Hospital Plan Corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this Act."

Section 3 of the Act expressly provides that "[t]his act shall take effect immediately and shall be retroactive to the extent provided in Section 2 hereof."

8. Plaintiff-intervenor DVHC, on behalf of plaintiff Methodist Hospital and others of the class which it represents in the Delaware Valley, and defendant Blue Cross adopted a contract, approved by defendant Insurance Department in accordance with 40 Pa. C.S. § 6124, under which defendant Blue Cross as insurer paid the Delaware Valley members of the hospital class ("provider hospitals") an agreed portion but less than all of the hospitals' actual cost of providing treatment for Blue Cross subscribers. This contract, as modified and extended by a "Summary of Principles to be Utilized in Drafting . . . [a never successfully negotiated] Interim 1973 Hospital Agreement," (together "Delaware Valley Agreement") terminated by its terms on March 31, 1974, and, subject to certain "run out" provisions providing for the orderly termination of coverage to individual subscribers,* defendant Blue Cross ceased to pay the hospitals directly pursuant to the terminated contract, but the patient-subscribers gradually became billable directly by the hospitals for the *full* costs of their hospitalization and treatment, just as are non-subscriber private paying patients. Plaintiff-intervenor Williamsport Hospital and others of the class which it represents in Northeastern Pennsylvania and Hospital Services Association of Northeastern Pennsylvania, a hospital plan corporation, adopted a contract ("Northeastern Pennsylvania Agreement") approved by defendant Insurance Department in accordance with 40 Pa. C.S. § 6124, under which Hospital Services Corpora-

* Pursuant to a Settlement Agreement reached in *Crozer Chester Medical Center, et al.* v. *Blue Cross of Greater Philadelphia,* No. 9799, 1974 Term (C.P. Del. Co. September 25, 1974), the "run out" provisions of the original contract as modified by the Summary of Principles went into effect on August 15, 1974. During this "run out" period, subscribers' coverages have terminated, each on its anniversary date, so that all coverage for all subscribers will have ceased as of August 15, 1975 but for the application of Act No. 94.

tion of Northeastern Pennsylvania as insurer pays the Northeastern Pennsylvania members of the hospital class an agreed portion but less than all of the hospital's actual cost of providing treatment for its subscribers, which contract remains in effect. Other hospital plan corporations throughout Pennsylvania have entered similar contracts with other members of plaintiff hospital class; some of the contracts had terminated before June 30, 1974, some since that date and some are still in effect.

Class Action Allegations

9. The present action is brought by the named plaintiffs on their own behalf and as representatives of a class, as defined in Rule 23 of the Federal Rules of Civil Procedure, comprised of all hospitals which were signatories to the Summary of Principles with defendant Blue Cross, which contract had lawfully terminated as of March 31, 1974, and which contract is now reinstated by the express provisions of the Act, and all those hospitals outside the Delaware Valley which have received payments from various hospital plan corporations so as to make them subject to the Act, and all executives, administrators, and employees of any of those hospitals responsible for the billing of patients, directly or indirectly, all of whom are liable to criminal prosecution under Section 6105 of Title 40 of the Pennsylvania Consolidated Statutes in the event of a failure to comply with the terms of the reinstated contract in accordance with the provisions of the Act. Similarly, the members of the hospital class are directly and the other members of plaintiff class are indirectly subject to the enforcement of the act by defendant Insurance Department. The members of the class within the Delaware Valley are, likewise, directly involved in the application of the contract, reinstated by the Act, between defendant Blue Cross and the Delaware Valley members

of plaintiff hospital class. The members of the class are so numerous as to make it impracticable to bring them before the Court. The questions of law and fact common to the class predominate over any question affecting individual members only. The claims of the representative plaintiffs are typical—if not identical—to the claims of the sub-class represented by each, and plaintiffs will fairly and adequately protect the interests of the class.

10. The prosecution of separate actions by individual members of the class would create the risk of:

(a) inconsistent or varying adjudications with respect to individual members of the class; and

(b) adjudications with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of the members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

COUNT I

(All Parties)

11. Paragraphs 1 through 10 of this Complaint are incorporated herein by reference.

12. Under the express provisions of Section 2(2) of the Act the Delaware Valley Agreement, terminated over a year ago, is reinstated as of its original termination date and, under the provisions of Section 1 of the Act, may not now be terminated without ninety days notice and without the consent of defendant Insurance Department for a period of up to ten months thereafter, all from the effective date of the Act.

13. The effect of the retroactive application of the Act to the above-mentioned contract would be to destroy the Delaware Valley plaintiff hospitals' legal right to full pay-

ment for services rendered Blue Cross subscribers, a right previously modified by agreement and restored, pending compliance with the "run out" provisions, when the contract embodying that agreement terminated on March 31, 1974. Thus, for the elapsed one year period since the "run out" provisions went into effect and for up to thirteen months hence, the Delaware Valley hospitals in plaintiff class will be required to accept partial payment for services for which they are entitled to full payment.

14. The Northeastern Pennsylvania Agreement, the Delaware Valley Agreement and the agreements between other hospital members of plaintiff class and other hospital plan corporations contain express contract terms providing that either party may cancel the agreement on ninety days notice to the other. Under Section 1 of the Act, the termination of these agreements following the ninety days notice is extended for periods of up to six months to permit defendant Insurance Department to conduct an investigation and make findings of fact. Only after such findings are made and only with the approval of defendant Insurance Department may the contracts be terminated. Moreover, at the option of defendant Insurance Department, the parties may be required to negotiate for a period of up to ninety days before an additional thirty day termination period begins.

15. The effect of the retroactive application of the Act to both of the above-mentioned contracts would be to destroy the Delaware Valley and Northeastern Pennsylvania plaintiff hospitals' legal right to full payment for services rendered to subscriber patients under the respective agreements, a right which was always available to the hospitals involved on ninety days notice. Thus, for a period of up to ten months following the decision of such hospitals in plaintiff class to terminate the applicable agreement, those hospitals will be required to accept

partial payment for services for which they are entitled to full payment.

16. Under Pennsylvania law, regardless of the provisions of the agreement between hospital members of plaintiff class and the respective hospital plan corporations, the hospitals have always had a right to terminate their agreements upon a breach by the hospital plan corporation. Under the terms of Section 1 of the Act, this right is abrogated and the agreements may not now be terminated without ninety days notice and without the consent of defendant Insurance Department for a period of up to ten months thereafter.

17. The effect of the retroactive application of the Act to all of the above-mentioned agreements would be to destroy the plaintiff hospitals' legal right to full payment for services rendered subcribers and to require performance of the agreements by the respective hospital plan corporations, a right that had always been available to the hospital plaintiffs upon breach of the agreements by the respective hospital plan corporations. Thus, for up to thirteen months after any breach of the agreements by a hospital plan corporation, the affected hospitals in plaintiff class will be required to accept partial payment for services for which they are entitled to full payment and to forego the remedy of termination of the agreements which would otherwise be available to them upon breach by the other party.

18. Under the terms of the contract imposed upon the plaintiff hospital class by governmental action, the hospitals cannot recover their legitimate costs of supplying services and facilities to hospital plan subscribers for the period from the time the contract lawfully terminated or could lawfully be terminated through the time that termination is to be deemed finally effective. This constitutes a governmental taking of property without

just compensation condemned by the Due Process Clause. *Louisville Joint Stock Land Bank* v. *Radford,* 295 U.S. 555 (1935); *Fornaris* v. *Ridge Tool Co.,* 423 F.2d 563 (1st Cir.), *rev'd on other grounds* 400 U.S. 41 (1970). Even with respect to public utilities, a state legislature has no power to impose contracts requiring the provision of service at confiscatory rates, like those imposed here, which do not permit a recovery of costs. *Prendergast* v. *New York Telephone Co.,* 262 U.S. 43 (1923).

19. Retroactive application of the Act to reinstate a contract already terminated or to take away the parties' contractual rights to terminate existing or reinstated contracts under the terms of those contracts or under state law existing at the time of contracting without protection of the substantial rights thereby affected, constitutes an impairment of contract prohibited by the Contract Clause. This is true regardless of the alleged public interest involved. *W. B. Worthen Co.* v. *Kavanagh,* 295 U.S. 56 (1935). *See Superior Motors, Inc.* v. *Winnebago Inds., Inc.,* 259 F. Supp. 773 (D.S.C. 1973).

20. Accordingly, both the Due Process and Contract Clauses prohibit retroactive application of the Act to a contract which had been lawfully terminated prior to its passage or which contained a right of termination agreed to before the passage of the Act, where the effect of such application would be to impose upon plaintiff hospitals a contractual obligation, which would not otherwise exist, to render service at a confiscatory rate which will not permit them to recover the legitimate costs of providing that service.

COUNT II

(All Parties)

21. Paragraphs 1 through 10 of this Complaint are incorporated herein by reference.

22. In the normal course of events, all of the hospital members of the plaintiff class will enter into future agreements with one or another hospital plan corporation as defined in Chapter 61 of Title 40, Pennsylvania Consolidated Statutes, 40 Pa. C.S. §§ 6101-27. As a result of the enactment of Act No. 94, each of these contracts will be subject to the limitations on termination contained in Section 1 of that Act.

23. Paragraph 16 of this Complaint is incorporated herein by reference.

24. As a result of the enactment of Act No. 94, hospital plan corporations, which are freed from the regulations applicable to other insurance companies writing health care insurance under 40 Pa. C.S. § 6103(a), will have an unfair advantage in their negotiations with plaintiff hospitals which will deny equal protection of the laws directly to other writers of health insurance and indirectly to the hospital members of plaintiff class by the effective weakening or exclusion of insurers other than hospital plan corporations from supplying insurance to patients in the hospitals in plaintiff class and forcing patients and the hospitals in plaintiff class to deal with the hospital plan corporations.

25. Paragraphs 11 through 15 and 17 through 20 of this Complaint are incorporated herein by reference.

26. Act No. 94 contains no severability clause, and its unconstitutional retroactive effect is reason for striking down the Act in its entirety.

COUNT III

(Defendants Fitzpatrick and Kane)

27. Paragraphs 1 through 26 of this Complaint are incorporated herein by reference.

28. Section 6105 of Title 40 prescribes criminal penalties against any person or legal entity violating any provision of that Chapter or any regulations or orders of defendant Insurance Department made pursuant thereto, which section is applicable to provisions of the Act amending 40 Pa. C.S. § 6124.

29. Defendant Kane as chief law enforcement officer of the commonwealth of Pennsylvania and defendant Fitzpatrick as chief law enforcement officer of Pennsylvania's most populous county are chief among those responsible for carrying out the enforcement of the criminal provisions applicable to violations of the Act. To protect members of plaintiff class from prosecution under the unconstitutional provisions of the Act, it is necessary that defendants Kane and Fitzpatrick be enjoined from instituting such prosecutions.

30. Moreover, having determined that the Act is unconstitutional for the reasons set forth above at paragraphs 13 through 26 of this Complaint, the Delaware Valley members of plaintiff class are now confronted with an insoluable trilemma: they are barred by the Act, upon pain of criminal prosecution under § 6105, from attempting to recover their costs, *inter alia,* by direct billing of patient-subscribers; they cannot bill defendant Blue Cross for the portion of their costs recoverable under the contract without risk of being estopped from pressing their constitutional challenge to the Act, *see, e.g., Wall* v. *Parrott Silver & Copper Co.,* 244 U.S. 407 (1917); and they are clearly not in a financial position simply to absorb the costs associated with treating Blue Cross subscribers —who constitute more than a third of the patient population of plaintiff hospitals—without billing either defendant Blue Cross or its subscribers pending the determination of this suit. This same trilemma will face other members

of plaintiff class as their agreements with their respective hospital service corporations expire or as they seek to terminate these agreements.

31. Unless plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable injury, being forced either to sacrifice a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to expose themselves to criminal penalties in order to preserve their constitutional challenge.

32. Unless plaintiffs are granted injunctive relief the public will suffer irreparable injury since non-profit hospitals cannot be forced to provide service to one-third of their patients at confiscatory rates without adversely affecting their service to the general public from whom their patient population is drawn.

33. The granting of a preliminary injunction will in no way harm defendants or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from plaintiff hospitals—including hospital plan corporation subscribers—must be responsible for the hospitals' legitimate costs of rendering these services.

COUNT IV

(Defendant Insurance Department)

34. Paragraphs 1 through 33 of this Complaint are incorporated hereby by reference.

35. Under Act No. 94, defendant Insurance Department must be given ninety days notice of every contract termination and, whenever that termination involves con-

tracts with hospitals having more than 5 percent of the beds in the area served by a hospital plan corporation, must hold public hearings and must suspend termination for up to six months to conduct an investigation, after which it must make findings of fact and either approve termination of the contract or recommend terms for its continuation. If defendant Insurance Department recommends terms for continuation, the termination of the contracts must be suspended, apparently by defendant Insurance Department, for up to ninety days. If no contract is reached during that period, the Department must approve termination of the contracts, but only to become effective after thirty days.

36. Under these provisions, defendant Insurance Department has the chief responsibility for executing and enforcing the unconstitutional provisions of Act No. 94. To protect members of plaintiff class from the execution and enforcement of these unconstitutional provisions of the Act, it is necessary that defendant Insurance Department be enjoined from executing and enforcing those provisions.

COUNT V

(Defendant Blue Cross)

37. Paragraphs 1 through 26 of this Complaint are incorporated herein by reference.

38. On August 5, 1975, defendant Blue Cross, without consulting with the Insurance Department of the Commonwealth of Pennsylvania or with representatives of plaintiff hospital class in the Delaware Valley, sent out a letter to the chief executive officers of the hospitals represented by plaintiff DVHC announcing that defendant Blue Cross would hereafter make payments under the terminated contract reinstated by Act No. 94. That letter

stated that "[b]y your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases . . . notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases." The letter further provided that each check would contain a restrictive endorsement incorporating this "understanding." A copy of the letter is attached hereto as Exhibit A.

39. On August 8, 1975, representatives of defendant Blue Cross and of Delaware Valley members of plaintiff hospital class, including plaintiff Guest, met under the auspices of the Commissioner of the Insurance Department of the Commonwealth of Pennsylvania to discuss the orderly implementation of Act No. 94 and the way in which its constitutionality could be challenged in the least disruptive manner. The representatives of defendant Blue Cross refused to participate in the meeting and walked out of it.

40. On August 11, 1975, defendant Blue Cross, without consulting with plaintiff DVHC or its member hospitals whose names were listed on the advertisement, caused a full page advertisement to be placed in the Philadelphia Inquirer which announced that "your Blue Cross card will be accepted by all member hospitals [of DVHC] as of August 2, 1975." The advertisement further stated that subscribers who were billed by hospitals represented by plaintiff DVHC during the period after the termination of the agreement between member hospitals and defendant Blue Cross are no longer liable for the full cost of their treatment and that those who paid that full cost should receive refunds from the hospitals. A copy of the advertisement was attached to the original complaint as Exhibit B.

41. Paragraph 30 of this Complaint is incorporated herein by reference.

42. By means of additional correspondence between Howard W. Baker, M.D., Vice President of defendant Blue Cross, and the Chief Executive Officers of plaintiff DVHC represented hospitals on August 20, 21 and 26, between Frank H. Abbott, counsel for plaintiff DVHC represented hospitals and William Zeiter, counsel for defendant Blue Cross, on August 21, 1975, and Mr. Zeiter's reply on August 22, and the letter of Mr. Abbott to Mr. Taylor on August 27, 1975 and Mr. Taylor's reply of the same date, all of which are attached hereto as Exhibit C, defendant Blue Cross manifested its intention to continue, insofar as possible, to enforce the unilaterally adopted position originally taken in its letter attached hereto as Exhibit A.

43. By means of the procedure outlined in the letter of August 5, 1975, and reaffirmed in the subsequent correspondence defendant Blue Cross has sought to prevent Delaware Valley members of plaintiff hospital class from recovering the full cost of services provided by these hospitals even if Act No. 94 is determined to be unconstitutional. By refusing to negotiate in the presence of the Insurance Commissioner and by placing its advertisement in the August 11, 1975 Philadelphia Inquirer, defendant Blue Cross has sought to force the Delaware Valley members of plaintiff hospital class to accept Act No. 94 whether or not it is constitutional, and has sought to prevent the development of an orderly procedure for testing the constitutionality of that Act without requiring that these members of plaintiff hospital class accept less than full compensation for services provided Blue Cross subscribers even if the Act is determined to be unconstitutional.

44. Unless Delaware Valley plaintiffs are granted injunctive relief against enforcement of the Act pending resolution of this action, they will suffer irreparable

injury, being forced either to sacrifice the benefits of a substantial constitutional challenge to the Act which, under applicable law, is almost certain to prevail upon the merits, or to receive no payments from defendant Blue Cross for services rendered to Blue Cross subscribers during the period in which they litigate this challenge.

45. Paragraph 32 of this Complaint is incorporated herein by reference.

46. The granting of a preliminary injunction will in no way harm defendant Blue Cross or the public, since it will do no more than preserve the status quo as it existed prior to passage of the challenged legislation and require that those receiving service from Delaware Valley hospital members of plaintiff class—including Blue Cross subscribers—must be responsible for the hospitals' legitimate cost of rendering those services.

WHEREFORE, plaintiffs pray that this Court:

(1) issue an order convening a three-judge district court as required by 28 U.S.C. §§ 2281 and 2284;

(2) advance this action on the docket and order a speedy hearing of this action according to law, and upon such hearing enter an order;

(a) declaring Act No. 94 unconstitutional for the reasons set forth in this amended complaint;

(b) enjoining preliminarily pending final resolution of this action, and permanently thereafter, enforcement and application of the Act insofar as it violates the constitutional rights of any of the members of plaintiff class as set forth in this complaint;

(c) enjoining preliminarily pending final resolution of this action defendant Blue Cross from taking any

action which would penalize members of the plaintiff class for raising a challenge to the constitutionality of Act No. 94; and

(d) granting such other and further relief as may be appropriate in the circumstances.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL
Attorneys for Plaintiff

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

Dated: September 12, 1975

(title omitted in printing)

MOTION TO INTERVENE AS PLAINTIFFS

Williamsport Hospital, Delaware Valley Hospital Association and Hospital Association of Pennsylvania move for leave to intervene as plaintiffs in this action in order to assert the claims set forth in the attached Complaint, on the ground that their challenge to the constitutionality of Act No. 94 presents issues of law and fact

in common with those arising from the claims of the original plaintiffs.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL

Attorneys for Williamsport Hospital, Delaware Valley Hospital Association, Hospital Association of Pennsylvania, Applicants for Intervention

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19107

Of Counsel

(title omitted in printing)

MOTION BY PLAINTIFFS TO ADD DEFENDANT

Plaintiffs move this Court for an order making the Insurance Department of the Commonwealth of Pennsylvania a party defendant herein and directing the issuance and service of process upon it, upon the following grounds:

1. This is an action for a declaratory judgment and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202 declaring Act No. 94, Act of August 2, 1975, amending § 6124 of Title 40 of the Pennsylvania Consolidated Statutes, repugnant to the Constitution of the United States and enjoining its enforcement against plaintiffs.

2. By the terms of Act No. 94, contracts specified thereunder may not be terminated without the prior approval of the proposed additional defendant which, therefore, is a proper party defendant to an action seeking to declare unconstitutional and enjoin enforcement of the Act insofar as it purports to confer authority on the Insurance Department of the Commonwealth of Pennsylvania to impair plaintiffs' contractual rights of termination.

3. The said Insurance Department of the Commonwealth of Pennsylvania is subject to the jurisdiction of this Court as to both service of process and venue, and can be made a party defendant herein without depriving the Court of jurisdiction.

/s/ JAMES D. CRAWFORD

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL

Attorneys for Williamsport Hospital, Delaware Valley Hospital Association, Hospital Association of Pennsylvania, Applicants for Intervention

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

(Proposed Order and Certificate of Service Omitted)

EXHIBIT A

BLUE CROSS OF GREATER PHILADELPHIA

August 5, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

On August 2, 1975, Governor Shapp signed into law Act No. 94 which requires that contractual relationships between hospitals and non-profit hospital plan corporations may only be terminated pursuant to that legislation. Accordingly, since the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement"), has not been so terminated, we will immediately move to take such administrative action as is necessary and appropriate in light of the reinstatement of the Agreement.

In that regard, it is requested that you immediately file your fiscal 1975-1976 budgets on the approved forms as required by Section 18 of the Agreement. Upon receipt of this information we will undertake the budgetary review process and thereafter establish, as appropriate, revised inpatient interim per diem rates. Furthermore, we are reviewing all Blue Cross cases which were previously paid on a non-member indemnity basis directly to Subscribers. At such time as this process has been completed, we will promulgate the administrative procedures we propose to follow in making any required retroactive payment, including restoration of the advances contemplated by the 1973 Summary of Principles.

Commencing immediately Blue Cross will make daily payments to all hospitals pursuant to the Agreement for

Covered Services rendered Subscribers on a current basis. These payments shall be based on the present interim inpatient per diem rates, which amounts will be adjusted when the budgetary information requested above has been received and approved. By your acceptance of these payments, you will be deemed to have agreed with us that such represent full payment for these cases, both inpatient and outpatient, subject only to the adjustments required by the Agreement, notwithstanding any subsequent decision as to the applicability or constitutionality of Act No. 94 to the Agreement or these cases. Moreover, each check representing such payment shall contain a restrictive endorsement indicating that such is made pursuant to this understanding and represents your full concurrence thereto. This policy is being adopted to eliminate any question as to the obligation of Blue Cross to make duplicate payments to the Provider and Subscriber for the same Covered Services.

The teletype confirmations which Blue Cross provides hospitals in response to inquires as to a given Subscriber's benefits shall, for the remainder of this month, indicate by the addition of a double asterisk (**) after their name those individuals who would have been entitled to member benefits without Act No. 94. This identification procedures is intended to quickly identify such cases for your continuing records.

If after reviewing the foregoing you have any question as to the methodology or procedure that Blue Cross intends to follow, please feel free to contact our offices.

Very truly yours,

/s/ Howard W. Baker,
Howard W. Baker, M.D.
Vice President

HWB:ccb

EXHIBIT C

BLUE CROSS OF GREATER PHILADELPHIA

August 20, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE
DVHC REPRESENTED HOSPITALS

Dear Sir:

Today the plaintiffs in *Guest, et al.* v. *Fitzpatrick, et al.*, Civil Action No. 75-2306, withdrew their request to have the United States District Court for the Eastern District of Pennsylvania enjoin the use by Blue Cross of the payment procedures described in my letter of August 5, 1975 (an additional copy of our letter of August 5, 1975 is enclosed for your convenience). Accordingly, since it is necessary that Blue Cross not be exposed to the obligation to make duplicate payments to the Provider and Subscriber for the same Covered Services, checks will continue to be issued with a restrictive endorsement.

However, it appears that there may be some misunderstanding concerning the purpose, scope and effect of the payment procedure adopted.

While Blue Cross will support the constitutionality of Act No. 94 in the pending litigation, there is no intention that the negotiation or transfer of Blue Cross checks will deprive any hospital payee of its right, should it desire to do so, to challenge the constitutionality of Act No. 94 generally or, once having cashed one or more Blue Cross checks with respect to certain admissions, to change its policy and refuse to accept and negotiate checks with respect to future or other admissions.

The purpose of the payment procedure is simply to eliminate the uncertainty produced by the attack on Act No. 94 by reaching a mutually-agreed settlement as to the payments to be made by Blue Cross and a subscriber to the Provider with respect to *only* those admissions covered by the particular check in question.

By negotiating or transferring a Blue Cross check which refers to this letter, the Provider will be agreeing that payment by Blue Cross under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") will be the only payment which the Provider will seek with respect to the particular admissions covered by the check in question, and that the Provider will not, *as to those particular admissions only*, make any direct claim against the subscriber not permitted by the Agreement.

We hope you will agree that this is a practical and responsible arrangement in light of the pending uncertainty over the status of Act No. 94.

If, after reviewing the foregoing, you have any questions as to the payment procedures which Blue Cross intends to follow, please feel free to contact our offices.

Very truly yours,

/s/ Howard W. Baker

Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure

Restrictive Endorsement

Front

"This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form."

Back

"The payee intending to be legally bound hereby agrees that by this negotiation or transfer of this instrument the payee named hereon agrees that it has accepted and will be bound by the provisions of the drawer's letter of August 6, 1975 to the payee relating to Act No. 94."

BLUE CROSS OF GREATER PHILADELPHIA

August 21, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE
DVHC REPRESENTED HOSPITALS

Dear Sir:

Under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") which has been reinstated by Act No. 94, Blue Cross is obligated to provide your hospitals with current financing (i.e.,

working capital advances). We desire to reinstate these advances as soon as practical, but we are faced with the uncertainty created by the pending litigation challenging the constitutionality of Act No. 94.

In the event Act No. 94 is declared unconstitutional, it will, of course, be appropriate for such advances to be returned to Blue Cross. Since in such an event Blue Cross will not be holding amounts payable to a hospital out of which to recover the advance, and since the very existence of the advance is a recognition on the part of a hospital of the need for working capital, effective provisions for repayment of these advances raises significant practical problems.

One option would be for a hospital to give Blue Cross appropriate security for prompt repayment of the advances, and we stand ready to discuss these arrangements on an individual basis, recognizing that Blue Cross will need to be provided with security of a quality and availability comparable to that contemplated by the Agreement under normal termination circumstances.

Recognizing that in some situations a hospital will not be in a position to offer such security, we believe that equivalent security would exist if a Provider agrees that in the event Act No. 94 is declared unconstitutional, it will thereafter voluntarily handle sufficient new admissions under the Agreement to exhaust the amount of the advance then outstanding. This is similar to the normal termination of the Agreement and should in general be fully compatible with your existing financing arrangements and restrictions.

In order to expedite payment of the advances, they are being tendered to you on the assumption that the arrangements stated in the previous paragraph are acceptable to you, and by negotiating or transferring the check or checks representing such advances you will be

deemed to have agreed to such contingent repayment arrangement.

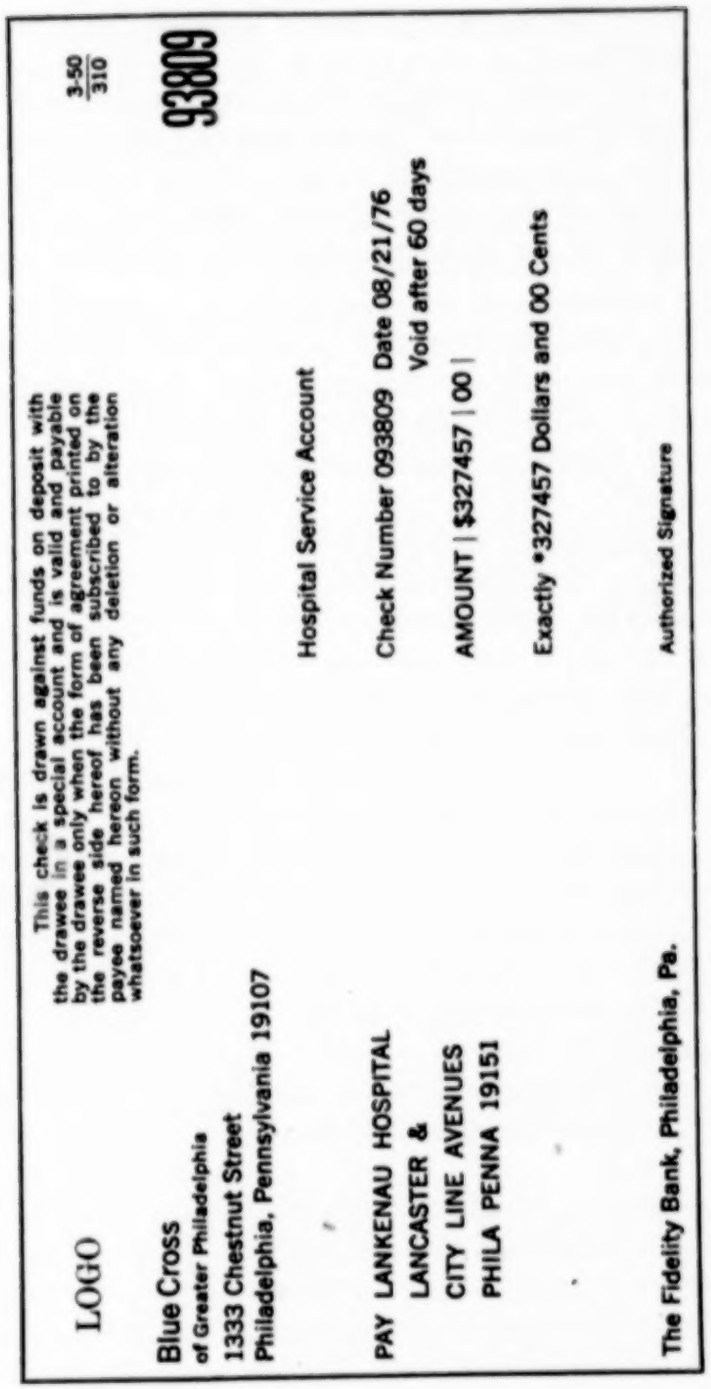
If you prefer to make other arrangements for security which is equivalent to the security which would exist under the Agreement in a case of normal termination, you should return the enclosed check, and advise us of the nature of the security which you can make available.

Very truly yours,

/s/ HOWARD BAKER

Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure



LOGO

Blue Cross
of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form.

3-50
310

93809

Hospital Service Account

Check Number 093809 Date 08/21/76
Void after 60 days

AMOUNT | $327457 | 00 |

Exactly *327457 Dollars and 00 Cents

PAY LANKENAU HOSPITAL
LANCASTER &
CITY LINE AVENUES
PHILA PENNA 19151

Authorized Signature

The Fidelity Bank, Philadelphia, Pa.

BLUE CROSS OF GREATER PHILADELPHIA

August 26, 1975

TO: THE CHIEF EXECUTIVE OFFICER OF
EACH DVHC REPRESENTED HOSPITAL

Since August 2, 1975 when Act No. 94 became law, we have been processing cases currently submitted to us for services to Blue Cross subscribers by your hospital. In other words, we have been transmitting eligibility information to you for the in-patient admissions and are paying you for these cases upon receipt of your billings. Likewise, we have been processing the current out-patient billings for payment to you. Therefore, it does not appear that there should be any difficulty on either our part or yours in the administration of Act No. 94 with respect to cases processed on or after August 2, 1975.

However, processing will be more difficult when dealing with prior cases and will require performance of a number of actions both by our staff and your business office personnel. We believe that the administrative procedures listed below will provide the quickest and most effective method whereby we can jointly accomplish what must be done with respect to *prior cases* affected by Act No. 94.

In-Patient Cases:

There are three possible categories into which these cases can be classified:

Category #1—Cases reported to Blue Cross but our non-member allowances had not yet been paid to subscribers:

Step A—You will receive approval forms from us within the next few days for each such

case. No action is required from you to obtain these approvals.

Step B—Your billings for these cases can then be submitted to us. They do not have to be separately identified by you.

Step C—Our reimbursement will be included in our daily payments to your hospital.

Category #2—Cases for which Blue Cross has already paid the non-member allowances to the subscribers:

Step A—You will receive approval forms from us for each such case. No action is required from you to obtain them. Since it will be necessary for us to prepare new computer programs in order to reconstruct this information, it will take approximately seven days to get these approval forms to you.

Step B—Based on the approval information, you can then process your billings for these cases in the usual manner and send them to us. They do not have to be separately identified by you.

We realize that you may have previously sent billings to us for many of these cases in this category; however, since they were prepared without any eligibility information from us, they did not include the Blue Cross allowance amounts for each class or charge (needed by both of us for final cost settlement purposes) nor did they reflect co-pay amounts required from subscribers.

Step C—Our reimbursement for these cases will be included in our subsequent daily remittances to your hospital. The reimbursements will

be reduced by any non-member allowances already paid by us for these cases. Separate detailed listings of these non-member payments will accompany each remittance to enable you to identify the cases to which they apply.

Category #3—Cases which were not previously reported to Blue Cross:

We believe that some in-patient cases with prior admission dates may not have been reported to us either by hospitals or subscribers. If, after receiving the approvals for categories 1 and 2 above, there are any other cases on your records for which you still lack approvals, please be sure to send us admission notices as soon as possible. Then Steps A, B and C listed under Category #1 should be followed.

Out-Patient Cases:

The out-patient cases can be classified into the same three categories as those described above for in-patient cases. However, the administrative procedures for accomplishing payment of prior cases can largely be accomplished by Blue Cross through some special programs which will be developed for our computer.

Category #1—Cases reported to Blue Cross but our non-member allowances had not yet been paid to the subscribers:

No action is required on your part, even though we may have previously returned the original out-patient billing forms to you. We have all the data needed to reimburse you for these cases and will begin processing them for payment to you this week.

Category #2—Cases for which Blue Cross has already paid the non-member allowances to the subscribers:

> Again, no action is required on your part. We will reprocess these cases as quickly as possible and you will receive payment for them in our subsequent daily remittances. The reimbursement will be reduced by any non-member allowances already paid by us for these cases. Separate detailed listings of these non-member payments will accompany each remittance to enable you to identify the cases to which they apply.

Category #3—Cases which were not previously reported to Blue Cross:

> We believe that some out-patient cases may not have been reported to us either by hospitals or subscribers. If, after receiving the payments for categories 1 and 2 above, there are any other cases on your records which have not been resolved, please be sure to send us out-patient billing forms as soon as possible so that we can process them for payment.

The combination of information on the approval forms, listings of non-member payments and your own records will enable you to determine whether a refund is due the subscriber or a further billing to the subscriber is appropriate.

The foregoing procedures contemplate that where Blue Cross has already paid a non-member allowance to a subscriber, the Provider may, of course, seek payment from the subscriber of an amount equal to the allowance. In order that there may be no question on this point, however, the fifth paragraph of my letter of August 20, 1975 is hereby modified to recognize and permit the practice of

collection by a Provider from a subscriber of an amount equivalent to any non-member allowance deducted from a daily remittance to the Provider. Reference on daily remittance checks to my letter of August 20, 1975 will hereafter be deemed to be a reference to such letter as modified by this paragraph.

A copy of this letter is being mailed to your Business Office Manager. Our Provider Relations Representative will be glad to answer any questions your Business Office may have about the procedures described above.

Very truly yours,

/s/ HOWARD BAKER

Howard W. Baker, M.D.
Vice President

HWB:ccb

SCHNADER, HARRISON, SEGAL & LEWIS

August 21, 1975

William Zeiter, Esquire
Morgan, Lewis & Bockius
123 South Broad Street
Philadelphia, PA. 19109

Re: Blue Cross letter of August 20, 1975 to Chief Executive Officers

Dear Mr. Zeiter:

The purpose of this letter is to confirm your statement to me of today that by cashing the checks referred to in your letter, the hospitals agree not to pursue any claims against the subscribers for whom Blue Cross has made payment, and Blue Cross agrees that even if Act 94 is held to be unconstitutional Blue Cross will not claim any refund of the monies paid. Furthermore, it is understood the cashing of the checks would have no effect on retroactivity of our current negotiations.

Sincerely yours,

/s/ Frank H. Abbott

Frank H. Abbott
For Schnader, Harrison, Segal & Lewis

MORGAN, LEWIS & BOCKIUS

August 22, 1975

Frank H. Abbott, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Re: Blue Cross letter of August 20, 1975 to Chief Executive Officers

Dear Mr. Abbott:

The first sentence of your letter of August 21, 1975 correctly summarizes the substance of our recent telephone conversation.

I am not clear as to the meaning of "retroactivity of our current negotiations" in the second sentence of your letter, but since I take it that it relates to a subject beyond the scope of the matters mentioned in the first sentence of your letter, you are correct that cashing of the subject checks would have no effect thereon.

With kindest regards,

Sincerely,

/s/ William E. Zeiter

William E. Zeiter

sk

cc: David S. Markson, Esquire

SCHNADER, HARRISON, SEGAL & LEWIS

August 27, 1975

Mr. Bruce Taylor
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, PA. 19107

Dear Bruce:

The purpose of this letter which is being sent on behalf of all the hospitals represented by the Delaware Valley Hospital Council in the current negotiations which Blue Cross is to inform you that the hospitals refuse to accept the terms and conditions set forth in Dr. Baker's letters of August 5, August 20 and August 21, 1975.

Act No. 94 makes no provisions for Blue Cross unilaterally making restrictions on the payments it makes to the hospitals. If anyone is to impose restrictions, it shall be the Court, by whose holding the hospitals will abide.

Accordingly, the hospitals refuse to accept or be bound by the restrictive endorsements on the checks being issued and the terms and conditions set forth in the letters. We have been instructed to inform you that on September 2, 1975 the hospitals will cash all checks in their possession and if you insist that the restrictive endorsements are binding, it is up to you to stop payment on the checks before September 2, 1975.

With best regards,

Sincerely yours,

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
FOR SCHNADER, HARRISON, SEGAL & LEWIS

August 27, 1975

HOSPITALS REPRESENTED BY THE
DELAWARE VALLEY HOSPITAL COUNCIL

Abington Memorial Hospital
All Saints Hospital
Booth Maternity Center
Bryn Mawr Hospital
Bryn Mawr Rehabilitation Center
Clement Atkinson Memorial Hospital
Crozer Chester Medical Center
Delaware County Memorial Hospital
Delaware Valley Hospital
Doylestown Hospital
Episcopal Hospital
Frankford Hospital
Germantown Dispensary & Hospital
Holy Redeemer Hospital
Jeanes Hospital
John F. Kennedy Memorial Hospital
Lankenau Hospital
Magee Memorial Hospital
Memorial Hospital, Roxborough
Mercy Catholic Medical Center Misericordia Division Fitzgerald Mercy Division
Methodist Hospital
Montgomery Hospital
Nazareth Hospital
Northeastern Hospital
Paoli Memorial Hospital
Phoenixville Hospital
Presbyterian-University of Pennsylvania Medical Center
Riddle Memorial Hospital
Sacred Heart Hospital, Chester
Sacred Heart Hospital, Norristown
Saint Christopher's Hospital for Children
Saint Joseph's Hospital
Suburban General Hospital
Taylor Hospital
West Park Hospital
Wills Eye Hospital

BLUE CROSS OF GREATER PHILADELPHIA

August 27, 1975

Frank H. Abbott, Esq.
Schnader, Harrison, Segal and Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Dear Frank:

This will respond to your letter of August 27, 1975 (copy attached) relating to negotiation of Blue Cross checks.

As you know from your participation in proceedings before the United States District Court for the Eastern District of Pennsylvania in *Guest et al* v. *Fitzpatrick et al,* Civil Action No. 75-2306, Blue Cross is exposed to a substantial risk of duplicate payment liability if Public Act No. 94 is held invalid.

In absence of the Act our obligation with respect to admissions in Delaware Valley Hospital Council represented institutions is solely to pay the non-member benefit to our Subscribers. Under the Act our obligation is to pay the Provider institution.

As you also know, the District Court, when considering your attack on our payment practices, made clear that Blue Cross has every right to protect the Plan against the risk of duplicate payment in the present uncertain circumstances. As a community agency responsible to our subscribers and the Pennsylvania Insurance Commissioner, we cannot permit large contigent liabilities for duplicate payments to accrue. Instead we have adopted procedures which permit the establishment of a definitive payment program for Providers; one which permits Blue Cross, the Subscriber and the Provider to

know immediately the economic consequences of a particular admission. In view of the indefinite time which a challenge to the validity of Public Act No. 94 will doubtless consume, and the availability throughout the community of a substantial number of member hospitals whose status is unaffected by the validity or non-validity of Act No. 94, such a clarification of the status of admissions to DVHC hospitals is clearly in the public interest.

Accordingly your counteroffer, as contained in your letter of August 27, 1975 must be, and is hereby, rejected. Any negotiation or transfer of our checks bearing reference to Dr. Baker's letters of August 5, August 20, August 21 and/or August 26, 1975 will be deemed an offer by the payee hospital to accept settlement with Blue Cross on the basis set forth in the applicable provisions of Dr. Baker's above-mentioned letters. In addition, because of the mechanical problems incidential to the administration of our Hospital Service Account, we could consider any further counteroffers on behalf of a payee hospital only when the counteroffer is accompanied by the return uncashed to Blue Cross of the Blue Cross check or checks to which the counteroffer relates.

Yours very truly,

/s/ Bruce Taylor

Bruce Taylor
President

BT:ccb

cc: CHIEF EXECUTIVE OFFICERS OF THE
DVHC REPRESENTED HOSPITALS

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 75-2306

PAUL I. GUEST, et al.,
Plaintiffs,

v.

F. EMMETT FITZPATRICK, et al.,
Defendants.

ORDER ADDING PARTY DEFENDANT AND GRANTING LEAVE TO INTERVENE AS PLAINTIFFS

This cause coming on to be heard on the motion of plaintiffs for an order making the Insurance Department of the Commonwealth of Pennsylvania an additional party defendant herein, and upon the motion of Williamsport Hospital, Delaware Valley Hospital Council and Hospital Association of Pennsylvania for leave to intervene as parties plaintiff, and it apearing to the Court that said Insurance Department of the Commonwealth of Pennsylvania is a proper party defendant in this action which may be served with process and joined without depriving this Court of jurisdiction, and that said Williamsport Hospital, Delaware Valley Hospital Council and Hospital Association of Pennsylvania should be permitted to intervene as prayed,

IT IS ORDERED:

That the Insurance Department of the Commonwealth of Pennsylvania be made a party defendant to this action; and that the caption of this action shall be amended in

accordance with the foregoing Amended Complaint, which has been filed and served upon the Insurance Department of the Commonwealth of Pennsylvania and the parties defendant, time to move, answer or otherwise plead to be in accordance with the agreement of the parties as approved by the Court.

AND IT IS FURTHER ORDERED:

That Williamsport Hospital, Delaware Valley Hospital Council and Hospital Association of Pennsylvania have leave to intervene in this action and are hereby made parties to this action in accordance with the foregoing Amended Complaint, already filed and served.

/s/ CHARLES R. WEINER
J.

Dated: September 19, 1975

Civil Action No. 75-2306

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; et al., etc.,

Plaintiffs,

v.

EMMETT F. FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General for the Commonwealth of Pennsylvania, Individually and in their Official Capacities and Blue Cross of Greater Philadelphia,

Defendants.

ORDER CONSTITUTING A THREE-JUDGE COURT

Pursuant to the provisions of Section 2284, Title 28, United States Code, I designate the Honorable Francis L. Van Dusen, United States Circuit Judge, and the Honorable Alfred L. Luongo, United States District Judge, to sit with the Honorable Charles R. Weiner, United States District Judge, as members of the Court for the hearing and determination of the above captioned matter.

/s/ COLLINS J. SEITZ

COLLINS J. SEITZ
Chief Judge
Third Judicial Circuit

Dated: September 30, 1975

(title omitted in printing)

MOTION FOR SUMMARY JUDGMENT
BY PLAINTIFFS AND PLAINTIFFS-INTERVENORS

Plaintiffs and plaintiffs-intervenors move this Court to enter, pursuant to Rule 56 of the Federal Rules of Civil Procedure, a summary judgment in their favor for the declaratory and injunctive relief prayed for in their Amended Complaint on the ground that there is no genuine issue as to any material fact and that they are entitled to a judgment as a matter of law for any or all of the following reasons:

a. The Act of August 2, 1975, Act 94, reinstates previously terminated contracts and authorizes the extension of pre-existing contracts, which retrospective application of the Act substantially alters and increases plaintiffs' obligations under those contracts in violation of both the Contract and Due Process Clauses of the Constitution of the United States;

b. In both its retrospective and prospective applications, Act 94 forces plaintiffs to provide service at non-compensatory rates and, thus, effects an unconstitutional confiscation of property and denies to those in plaintiff hospital class equal protection of law; and

c. The retrospective and prospective applications of Act 94 are so interdependent as a matter of both statutory construction and legislative intent that even if the Act is found to be unconstitutional only in its retrospective application, the entire Act must be stricken.

This motion is based upon

a. the Amended Complaint,

b. the attached affidavit, and

c. the Memorandum of Plaintiffs and Plaintiffs-Intervenors in Support of Motion for Summary Judgment.

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
JAMES D. CRAWFORD
SUSAN L. CARROLL
Attorneys for Plaintiffs and Plaintiff-Intervenors

SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102

Of Counsel

Dated: October 7, 1975

(Certificate of Service Omitted in Printing)

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } SS.

EDWARD J. ARMSTRONG, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the Administrator of Jeanes Hospital, a non-profit corporation organized under the laws of Pennsylvania and located at 7600 Central Avenue, Philadelphia, Pennsylvania 19111.

2. That he is responsible for maintaining the fiscal viability of Jeanes Hospital and has final authority for recommending to the board of trustees a schedule of patient charges in accordance with this purpose; he has discharged essentially these duties under various titles for 15 years.

3. That legitimate patient charges are based on the true total cost associated with services provided that patient which cost includes, in addition to expenses incurred in the actual treatment of the individual patient, a pro rata share of the cost of maintaining the hospital and performing its duties of public service to the community to the extent that these costs are otherwise unreimbursed.

4. That a non-profit hospital must allocate among charges to paying patients the otherwise unreimbursed costs of community service activities and its own main-

tenance expenses or it cannot remain financially solvent and continue to perform its obligations to the extent and at the level required by law in accordance with the basic purposes of a non-profit medical institution.

5. That on July 1, 1971, Jeanes Hospital entered into a contract with Blue Cross of Greater Philadelphia ("Blue Cross"), which contract with amendments thereto is referred to in the Amended Complaint as the Delaware Valley Agreement.

6. That under this Agreement, Blue Cross agreed to pay Jeanes Hospital the reasonable cost of covered services furnished its subscribers, but no part of the expenses incurred by the hospital in providing care to indigents, in writing off uncollectible accounts other than those of Blue Cross subscribers, in providing charity allowances, and in undertaking certain educational and research activities.

7. That, as regards payment under the contract as reinstated by Act 94, Blue Cross has directed Jeanes Hospital that unless it is willing to negotiate a new payment ceiling, *i.e.* a percentage limitation over allowable costs for the previous year, it will be reimbursed in accordance with the ceiling limitation contained in a 1974 Agreement negotiated by Blue Cross with entirely different parties. This unilateral policy was announced in a letter to Jeanes Hospital identical to that included at Exhibit "C" to the Memorandum of Plaintiffs and Plaintiffs-Intervenors in Support of Motion for Summary Judgment.

8. That the costs which Blue Cross does not define as reasonable and will not reimburse, and that further proportion of costs defined as reasonable but which might exceed the ceiling limitation on Blue Cross payments, are costs which would normally be allocated among all of the

paying patients at Jeanes Hospital in accordance with accepted accounting procedures.

9. That Blue Cross' refusal to recognize these costs results in a loss to Jeanes Hospital which must then either be allocated among the remainder of its paying patients who are not Blue Cross subscribers, such that this latter group is forced to pay more than their share of the community service and hospital maintenance costs which are not recoverable under the Delaware Valley Agreement for service rendered Blue Cross subscribers, or must be carried as losses.

10. That because of its relatively small indigent patient population, the loss suffered by Jeanes Hospital as a result of reduced costs payable by Blue Cross is smaller than that sustained by nearly every other hospital in the Delaware Valley, but still amounts to more than $50,000 a year.

11. That this loss is multiplied over time because, although Blue Cross will pay its shares of depreciation of hospital buildings and equipment, the portion of its payment which should be segregated, funded and invested towards future replacement costs, must necessarily be used by Jeanes Hospital to meet those of its immediate operational expenses which Blue Cross will not pay. Thus, the hospital loses the accumulated interest it would have earned had the money earmarked for depreciation been available for investment. Further, since Blue Cross payments are received on a piecemeal basis, even that portion which can be placed in a depreciation fund cannot possibly be invested at rates which will keep pace with inflation.

12. That for these reasons, although the Jeanes Hospital plant is nearly fully depreciated (having been erected in 1928), the hospital has invested only a fraction of the present replacement cost of its plant. This is a direct

result of the failure of the Blue Cross payment formula to account for an operating growth needs factor, which factor is recognized by Blue Cross in its contracts with hospitals in other states.

13. That a further result of the fact that Jeanes Hospital must borrow against its depreciation funding just to meet its daily costs of operation is that the hospital has almost no cash available for purchases of new equipment and cannot, in accordance with proper fiscal policies, develop reserves which would enable it to keep pace with the rapidly expanding technology in the health care field. Thus, as a result of Blue Cross' partial and after the fact method of payment, the hospital will normally be forced to borrow the purchase price of new equipment. Blue Cross will bear its subscribers' share of this cost through depreciation; however the cost to the entire system—Blue Cross subscriber-patients in common with all paying patients—will be nearly double the cash purchase price of that equipment over a ten year use period at present interest rates. In many cases, rather than impose this cost on the system, the hospital may forego or delay the purchase of new equipment even though its value is well established.

14. That the effect of Blue Cross' failure to reimburse Jeanes Hospital the true total costs of providing service to Blue Cross subscribers is thus two-fold. It results in an immediate loss to the hospital which must be subsidized by increased charges to other paying patients, and it further creates a cash shortage which is projected into the future and multiplied over time to make it impossible for the hospital to account for its operating growth needs and keep pace with rapidly improving technology in hospital equipment.

15. That if all patient care were paid for on the same basis as that provided for in the Delaware Valley

Agreement, Jeanes Hospital would necessarily be unable to provide even the minimal quality of health care services required to maintain its accreditation.

16. That, based on personal knowledge of Blue Cross contracts in other cities and certain statistical studies performed by the American Hospital Association (*e.g.*, a survey compiled by Thomas P. O'Hare and released on February 28, 1974, and another prepared in November of 1971), there appears to be a distinct correlation between the terms on which Blue Cross reimburses member hospitals in various cities and the percentage of the health care insurance market which Blue Cross occupies in those same cities. Thus, the Blue Cross contracts in New York, the District of Columbia, Detroit, Boston and Cleveland are all cost-based as is the Delaware Valley Agreement in Philadelphia. In each of these cities including Philadelphia, Blue Cross enrolls close to or in excess of 50% of those purchasing health care insurance. Conversely, in cities like San Francisco, Phoenix and Houston where Blue Cross operates on an indemnity basis, its share of the relevant market is less than 20%.

The foregoing is true and correct to the best of my personal knowledge.

/s/ EDWARD J. ARMSTRONG

Edward J. Armstrong

(Oath and Jurat Omitted in Printing)

(title omitted in printing)

JOINT MOTION OF THE DEFENDANTS BLUE CROSS OF GREATER PHILADELPHIA, ROBERT P. KANE, ATTORNEY GENERAL, AND THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA FOR A SUMMARY JUDGMENT

1. The plaintiffs in this case contend that the act of August 2, 1975 (No. 94) of the Commonwealth of Pennsylvania is unconstitutional and seek equitable and declaratory judgment relief.

2. The defendants Blue Cross of Greater Philadelphia, Robert P. Kane, Attorney General, and the Insurance Department of the Commonwealth of Pennsylvania contend that the Act is constitutional.

3. Based upon the affidavits in support of this motion and the brief of the defendants, the defendants respectively request that a summary judgment be granted denying the relief requested by the plaintiffs, and a declaration that the Act is constitutional.

/s/ DENIS V. BRENAN

DENIS V. BRENAN

/s/ HOWARD M. HOLMES

HOWARD M. HOLMES
206 State Office Building
Philadelphia, Pa. 19130
Attorney for Defendants
Robert P. Kane, Attorney General
The Insurance Department of the Commonwealth of Pennsylvania

/s/ WILLIAM E. ZEITER

WILLIAM E. ZEITER
2100 The Fidelity Building
Philadelphia, Pa. 19109
Attorneys for Defendant
Blue Cross of Greater Philadelphia

Of Counsel:
MORGAN, LEWIS & BOCKIUS

(Certificate of Service Omitted in Printing)

AFFIDAVIT

BRUCE TAYLOR, being duly sworn, deposes and says:

1. I am the President of Blue Cross of Greater Philadelphia and have been associated with this organization since 1939. During this period, I have held positions successively as Accounting Department Unit Supervisor, Administrative Assistant, Assistant Vice President, Vice President and Executive Vice President. Further, I have served as a member of numerous national, regional and local organizations concerned with health care delivery, including acting as an advisor to various United States and Pennsylvania Senate and House Committees, as well as the Social Security Administration.

2. The Blue Cross system, as it is known today, is composed of eighty independent non-profit corporations known as Plans. These organizations, located throughout the United States, Canada, Puerto Rico, and Jamaica provide for the financing of health care benefits to approximately 87 million individuals. When combined with the 32 million people covered under federal government programs administered by Blue Cross Plans, the total number of individuals served by these organizations exceeds 117 million.

3. The Blue Cross concept originated in 1929 when Justin Kimball, then Executive Vice President of Baylor University, developed a pre-paid hospitalization program for Dallas school teachers. Under this program, each teacher paid fifty cents a month to the University Hospital and was in turn assured of receiving up to twenty-one days of hospital care without further charge. Although the Baylor program was an immediate success, being widely copied in other areas, it was apparent that the single hospital—single group program was of limited usefulness,

especially in cities having several hospitals. Thus, in subsequent years groups of hospitals joined together to initiate community-wide pre-payment plans whose growth and acceptance were fostered by the adverse economic situation of the times which otherwise would have precluded many people from obtaining necessary hospital care.

4. Initially the pre-paid hospitalization programs were sponsored by diverse organizations ranging from the council of social agencies to local business groups, community funds, or the hospital council. To bring these various insurance programs under the control of state regulators, statutes were passed in many jurisdictions authorizing the formation of non-profit hospital plan corporations. One of the earliest, the Hospital Service Association of Minnesota, was incorporated in 1933. Its director, Mr. E. A. van Steenwyk, began using a blue cross on his stationery, information folders and posters as an identification symbol for the organization. The symbol gained quick acceptance and it was only a short time later that the Hospital Service Association became known as "Blue Cross".

5. The concept of pre-paid hospitalization coverage was explored in Philadelphia by a group of civic leaders in 1936. As a result of their action, and the efforts of the then Insurance Commissioner, Mr. Owen Hunt, enabling legislation was passed permitting the creation of pre-paid hospital benefit corporations in the Commonwealth of Pennsylvania as the financing mechanism for meeting community needs for hospital care. In 1938, Blue Cross of Greater Philadelphia, then known as The Associated Hospital Service of Philadelphia, was formed with $30,000 borrowed from the Community Chest. In its first year of operation the Plan enrolled 28,000 members. Today, over

three and a half decades later, this total has grown to approximately 2,400,000 subscribers.

6. Subsequent to the formation of the Philadelphia Plan, other Plans were established to cover the remainder of the Commonwealth of Pennsylvania. Today, in addition to Blue Cross of Greater Philadelphia, there are four other Plans serving the citizens of Pennsylvania: Capital Blue Cross (Harrisburg), Blue Cross of Lehigh Valley (Allentown), Blue Cross of Northeastern Pennsylvania (Wilkes-Barre) and Blue Cross of Western Pennsylvania (Pittsburgh). These five Plans currently serve a majority of the residents of Pennsylvania or approximately 6.5 million policyholders, known as Subscribers, dispensing in excess of 600 million dollars annually in benefit payments.

7. The Philadelphia Plan is incorporated under the Non-profit Corporation Law of 1972 and regulated by the Pennsylvania Insurance Department as a hospital plan corporation (40 Pa. C.S. § 6101, *et seq.*), which among other things requires the Insurance Commissioner to approve all hospital contracts and "rates of payments to hospitals". A copy of the Plan's Articles of Incorporation which may be amended only with the approval of the Insurance Commissioner and Governor of the Commonwealth of Pennsylvania are attached hereto as Exhibit 1.

8. The Plan's affairs are guided by a Board of Directors composed of thirty-four individuals elected by vote of Subscribers, and four ex-officio members. Seven of the elected directors are nominated by state and local officials representing the communities the Plan serves. Further, to ensure broad-based representation, only three hospital trustees and three physicians may serve on the Board at any time, and the By-Laws specifically preclude election of any salaried hospital employee other than a physician. The By-Laws, which set forth the duties and

responsibilities of the Plan's officers and directors, are attached hereto as Exhibit 2.

9. Importantly, the By-Laws include provision for an independent Consumer Advisory Committee composed of a cross-section of Subscribers, whose Chairman and Vice Chairman are ex-officio voting members of the Board of Directors. As provided in Section 3.18 of the By-Laws, the nucleus of this Committee is composed of individuals appointed by the Governor of Pennsylvania, Mayor of the City of Philadelphia, President of the Philadelphia City Council, and the Chairman of the respective Boards of Commissioners of Bucks, Chester, Delaware and Montgomery Counties.

10. Blue Cross coverage differs substantially from that provided by a commercial insurance company in the important areas of benefits and method of operation. Blue Cross contracts with its Subscribers on a non-profit basis under either individual or group policies called Subscription Agreements. However, the Plans do not stop there. They then negotiate contracts directly with area hospitals to furnish covered services to Subscribers without charge to these individuals, other than the modest deductible or coinsurance amount which may be required by their respective Subscription Agreements. The contracting hospitals, known as "Member Hospitals", are paid directly by Blue Cross for services rendered Subscribers as provided by their then Blue Cross-Hospital Agreement. Thus, unlike commercial insurance companies, Blue Cross provides service benefits rather than a specified dollar sum or indemnity. The advantage of such coverage is obvious for the charges levied by hospitals vary significantly between hospitals and within a given hospital depending upon the scope of services required for a specific illness. In recent years hospital charges have risen at such rapid rates that

any fixed indemnity coverage would quickly become insufficient.

11. Service benefits do not disappear merely because a Subscriber travels or is treated at a Member Hospital which does not have a contract with the Subscriber's Plan. Recognizing the mobility of our population, the Plans developed what is now known as the Inter-Plan Service Benefit Bank. Through this mechanism, the Plan serving the area in which the Member Hospital is located authorizes the treatment of the Subscriber and then charges the cost back to the Subscriber's Plan through the Bank. A fuller and more complete description of this coordinated effort which ensures national coverage is attached as Exhibit 3.

12. All Plans, including those located in Pennsylvania, are members of the Blue Cross Association, headquartered in Chicago, Illinois. Membership in this organization which establishes national policy, operates the Inter-Plan Service Benefit Bank and licenses the use of the Blue Cross symbol is closely monitored and strict standards of service are imposed on all Plans. A detailed explanation of these procedures is set forth in Exhibit 4, while the 1974 Fact Book included as Exhibit 5 provides extensive data with regard to the overall operations of the 80 individual Plans.

13. In addition to its other functions, the Blue Cross Association also acts as agent for the Individual Plans in arranging national contracts with major corporate employers which have undertaken responsibility for certain uniform benefits to their employees located in various parts of the country as a result of collective bargaining. Further, the Association as prime contractor with the Civil Service Commission sub-contracts with local Plans to provide health care protection for federal employees

under the Federal Employees Health Benefits Program and, as prime contractor with the United States Department of Defense, supervises the program which serves more than a million dependents and retirees of the armed forces through CHAMPUS-Civilian Health and Medical Program of the Uniformed Services.

14. Prior to the July 1, 1966 effective date of Title 18 of the Social Security Amendments which created Medicare (the national health programs for persons 65 and older), the U.S. Department of Health, Education and Welfare signed a contract with the Blue Cross Association designating the Association as "intermediary" between the government and most of the country's voluntary hospitals. Under this accord, and pursuant to subsequent contracts, the Blue Cross Plans perform a wide range of functions in communications, claims processing, utilization review and audit necessary for operation of that portion of Medicare which provides institutional benefits. All Pennsylvania Plans actively participate in this work.

15. The 1965 Amendments to the Social Security Act also included as Title 19, the state-initiated, state and federally financed program of medical assistance for the poor. Locally, the Pennsylvania Plans process claims under this program on behalf of the Commonwealth's Department of Public Welfare and otherwise assist in this state-operated endeavor.

16. For many years most Blue Cross coverage was provided on a group basis through the individual's employer or union. Although this is still the prevailing practice, the Plan has developed several contracts for use by individuals who are not members of a group. Presently, the Philadelphia Plan offers three non-group Subscription Agreements: Co-Pay Preferred Comprehensive (Exhibit 6), $250 Deductible (Exhibit 7), and for those individuals

receiving Medicare benefits, a 65 Special Agreement is available (Exhibt 8). Further, in cooperation with Pennsylvania Blue Shield, the Plan also offers a Non-Group Major Medical Program which can be added to the basic Subscription Agreements (Exhibit 9). Copies of the approvals issued by the Pennsylvania Insurance Department authorizing these policies are included with the respective Subscription Agreements in the accompanying exhibits.

17. Although group contracts vary substantially with regard to the extent and length of coverage, those offered by the Philadelphia Plan contain essentially the same general provisions. A representative group contract is attached as Exhibit 10.

18. Since many "groups" are too small to develop their own representative usage experience, Blue Cross has traditionally issued a non-credible group policy for these organizations; a representative form of which is attached as Exhibit 11. Except as to the method of computing premium rates, the group and non-credible group contracts are essentially the same as both may be modified to meet particular situations or circumstances.

19. Although the Plans contract with substantially all accredited hospitals, some are avoided either because of the hospital's wishes or the Plan's desire not to contract with unsafe or unneeded institutions. Any hospital not contracting with a Plan is known as a "Non-Member Hospital".

20. Although the primary purpose of the Plan is to bring to its Subscribers the benefits of its contracts with Member Hospitals, it also recognizes that individuals may desire because of location or availability, or be required, due to the affiliation of their physician, to seek hospital care at a Non-Member Hospital. Therefore, the Subscrip-

tion Agreements, both group and non-group, contain an indemnity benefit which is payable to the Subscriber in such event. Since this payment may be substantially less than the amount billed by the hospital, such provides far less coverage than the normal service benefit.

21. The Philadelphia Plan initially negotiated rates of reimbursement on a hospital-by-hospital basis so as to achieve a favorable rate differential for Subscribers. Indeed, by the late 1950's most Blue Cross Hospital contracts were cost-related, as was the Standard Blue Cross Member Hospital Contract offered by the Philadelphia Plan. A copy of this agreement, dated July 1, 1958, is attached as Exhibit 12 ("1958 Agreement").

22. Under the 1958 Agreement, reimbursement was initially established by negotiation utilizing cost data with subsequent years' rates made subject to annual escalation based upon the Cost Index derived from published records of the U.S. Bureau of Labor Statistics.

23. With the advent of Medicare in 1966, the then Pennsylvania Insurance Commissioner ordered all Pennsylvania Plans to renegotiate their hospital contracts based on the cost accounting principles which guided Medicare. The outgrowth of that negotiation was the Uniform Cost Contract—1967 ("1967 Agreement"), a copy of which is attached hereto as Exhibit 13. Interestingly, since the 1967 Agreement was not executed until after the commencement of the fiscal year 1968, it was necessarily made retroactive to July 1, 1967.

24. Under the reimbursement provisions of the 1967 Agreement, accountants annually determine the total cost of operating a hospital and the proportion of that cost represented by services utilized for Blue Cross Subscribers. This cost, subject to audit adjustments by independent certified public acountants is then reimbursed to the hospital by the Plan.

25. In 1971, during a public hearing considering proposed increases in Subscriber rates, the then Pennsylvania Insurance Commissioner, Herbert S. Dennenberg, ordered the 1967 Agreement cancelled, and immediate negotiations commenced to develop a new agreement. A copy of the Commissioner's letter confirming this order is attached as Exhibit 14.

26. Subsequent to this action, the Insurance Commissioner promulgated detailed Guidelines, which he indicated must be addressed in any new agreement. These items included further quality control standards designed to insure greater efficiency and economy, increased public accountability, imposition of cost ceilings, and a substantial number of consumer-oriented measures variously described as a patient's "Bill of Rights". A copy of these Guidelines, and the several subsequent additions thereto are included herewith as Exhibit 15. In 1974, when the present Insurance Commissioner, William Sheppard assumed office, he issued a news release advising that the control measures previously mandated by the Insurance Department would be continued. A copy of this release is attached as Exhibit 16.

27. As a result of lengthy arms-length negotiations, attended regularly by representatives of the Insurance Department, including the Commissioner, spanning over a year-and-a-half, a contract was finally achieved between the Philadelphia Plan and area hospitals. This accord, the Hospital Agreement, July 1, 1971 ("1971 Agreement"), is attached as Exhibit 17. Since the 1971 Agreement was not finally executed until 1972, the pattern established with the 1967 Agreement was followed and it was made retroactive to July 1, 1971.

28. Although the specific agreements negotiated by the other Pennsylvania Plans include provisions especially adapted to their service areas, all base reimbursement on

cost and contain quality control provisions responsive to the Insurance Department's Guidelines.

29. Section 18.4 of the 1971 Agreement imposed a specific cost ceiling on the reimbursement payable to Member Hospitals. For fiscal year 1971-1972 any amount exceeding 112% of the cost allowable in the prior fiscal year was disallowed. This Section also contemplated a further contractual limit for fiscal 1972-1973, but with the implementation of the Economic Stabilization Act, it was agreed by the contracting parties that the limitations imposed by the Act would serve as an alternative ceiling. The amendment to the 1971 Agreement, effective July 1, 1972, which adopted this cost ceiling is attached as Exhibit 18.

30. Since the 1971 Agreement was to expire by its terms on June 30, 1973, the Plan, by letter to the hospitals' bargaining unit, the Delaware Valley Hospital Council ("DVHC"), dated December 29, 1972, called for new negotiations. A copy of this letter, setting forth nine specific areas the Plan wished to explore for inclusion in a new contract, is attached as Exhibit 19.

31. At the first negotiating session held in response to the foregoing invitation on March 2, 1973, the Plan's negotiators expanded upon the areas identified in its earlier letter noting the Plan desired to add improved cost containment provisions. For its part, the DVHC's negotiating posture was largely one of seeking to eliminate cost ceilings, while cutting back on the quality controls imposed by the 1971 Agreement.

32. Following thirty-seven lengthy and difficult negotiating sessions, which were frequently attended by representatives of the Pennsylvania Insurance Department, the Plan and DVHC reached tentative agreement on December 26, 1973 as to a one year extension of the 1971 Agreement, that is, through June 30, 1974. A copy of this document,

known as the 1973 Summary of Principles ("1973 Agreement") is attached as Exhibit 20. Under the terms of this accord, the prior practice of making retroactive adjustments was continued, as the effective date of the 1973 Agreement was July 1, 1973.

33. During the period while the Plan was negotiating an extension agreement with the DVHC, the Insurance Department ordered the then existing Blue Cross contract with proprietary hospitals, those operated for profit, to be renegotiated so as to incorporate the quality control provisions included in its Guidelines. A copy of the Commissioner's letter ordering this modification is attached as Exhibit 21.

34. After a relatively short period of negotiations with representatives of the proprietary hospitals, agreement was reached as to a new form of contract which not only responded to the Guidelines, but also the further reforms sought by the Plan in its negotiations with the DVHC. A copy of this contract, known as the 1973 Proprietary Hospital Agreement ("Proprietary Agreement"), is attached as Exhibit 22. Following the practice established with the non-profit hospitals, the Proprietary Agreement was made retroactive.

35. The 1973 Agreement terminated by its own accord on June 30, 1974, but through unilateral extensions granted by the Plan, it was continued through August 15, 1974 in hopes of resolving the negotiating impasse. However, the DVHC steadfastly refused to consider any effective cost containment measures, improved utilization review procedures, or greater patient rights, stating they would not accept any of the new procedures included in the Proprietary Agreement. Indeed, the DVHC, as bargaining agent for these "non-profit" hospitals, argued they would not recommend any contract which did not have a

profit factor, that is, a percentage allowance in excess of the actual cost of Subscriber care.

36. The effectiveness of the extensions granted by the Plan was subsequently challenged by certain of the DVHC represented hospitals in an action instituted in the Court of Common Pleas of Delaware County known as *Crozer-Chester* v. *Blue Cross of Greater Philadelphia* (Docket No. 9799 of 1974). However, this action was subsequently resolved by a Settlement Agreement entered on September 25, 1974, a copy of which is attached as Exhibit 23, whereby the extensions were accepted as valid and binding on the DVHC represented hospitals.

37. Under the terms of the 1971 Agreement, as amended and supplemented by the 1973 Agreement, Subscribers are entitled to continue receiving full service benefits at DVHC represented hospitals until the next anniversary date of their Subscription Agreement with the Plan following the termination of the 1973 Agreement. Thus, large numbers of Subscribers were granted continued service benefits at these institutions up until August 15, 1975. Payments to the hospitals for services rendered to a gradually decreasing proportion of the Plan's Subscribers during that period were made as provided in the 1973 Agreement, as supplemented by the Settlement Agreement.

38. Since the impact of the termination was not immediately felt by most Subscribers, the effect on the Philadelphia area hospital delivery system was gradual but significant. When a Subscriber, whose anniversary date had passed, attempted to obtain hospital services he was confronted with a request for a cash deposit, pledge or other security. No longer did the Blue Cross card ensure the individual that his bill could and would be paid. Rather, Subscribers seeking to use these now Non-Member Hospitals were faced with the prospect of either paying

bills, which in some cases exceeded their total net worth, or deferring necessary hospital care.

39. Although the assured cash flow the hospitals had traditionally received from Blue Cross was slowly reduced as more Subscribers lost service benefits, the hospitals, in many cases, were not adversely affected. The termination of the 1973 Agreement meant these now Non-Member Hospitals could charge patients whatever they wished. Absent a contract, cost no longer was the guide to reimbursement. Recognizing that patients select a physician and not a hospital, most Subscribers continued to enter community hospitals, whether they were Member or Non-Member. This admission practice, when coupled with the unlimited charges the hospital could command, did not make the negotiation of a new contract desirable. The result of this turn of events was to diminish the quality controls, cost containment measures and patient rights which Blue Cross and the Insurance Department had labored long to achieve.

40. Recognizing that this development was not in the best interests of the communities they serve, all Philadelphia medical school hospitals, as well as a number of community hospitals, abandoned the DVHC position. A statement issued by the medical school hospitals on August 14, 1974 explaining their position and reasons for seeking separate negotiations with the Plan is attached as Exhibit 24.

41. Following a relatively short period of negotiations with this independent group of hospitals, their representatives reached a contractual understanding with the Plan which was embodied in a document entitled "Memorandum of Agreement", a copy of which is attached as Exhibit 25. This understanding incorporated many of the principles sought by the Plan during its negotiations with the DVHC, but also added several new concepts reflective of

today's economic situation. For example, a flexible cost ceiling developed by the Wharton School at the University of Pennsylvania was included, together with incentive payments for increased efficiency and more comprehensive utilization review.

42. Subsequently, a formal accord was drafted incorporating the various principles contained in the Memorandum of Agreement and such was approved by the Pennsylvania Insurance Department ("1974 Agreement"). A copy of the 1974 Agreement with the approval letter of the Insurance Department is attached as Exhibit 26. Again, as was the pattern with prior accords, this Agreement was made retroactive.

43. Although the 1974 Agreement was offered all hospitals represented by the DVHC, most have rejected it notwithstanding the recommendations of organized labor, the Greater Philadelphia Chamber of Commerce, and Greater Philadelphia Movement. Copies of the letters from these labor, business and community organizations expressing their accord with the Blue Cross' position are attached hereto as Exhibit 27.

44. Early in 1975, in an effort to lift the negotiation stalemate between the Plan and DVHC represented hospitals, the Pennsylvania Insurance Department intervened as a mediator, unfortunately without success. Similarly, although Governor Shapp personally entered the negotiations, participating in three full-day sessions, an agreement was not reached as the DVHC negotiators steadfastly insisted upon a profit percentage and abandonment of quality controls as the price of a contract. Attached as Exhibit 33 is a memorandum and letter from the DVHC counsel setting forth their negotiating position.

45. Faced with this health care crisis which could well spread through the Commonwealth, the General Assembly, reacting to the needs of its constituents, passed House

Bill No. 1347 which was subsequently signed into law by the Governor as Public Act No. 94. A copy of the Act is attached as Exhibit 28.

46. Public Act No. 94 recognizes the significant impact discontinuance of Blue Cross coverage would have on the general populace. It requires that hospital contracts may only be terminated after notice is first given the Pennsylvania Insurance Department, which in turn is afforded an opportunity to initiate fact-finding, call negotiations, conduct public hearings, and finally to recommend appropriate solutions. During this period, the terminated contract is reinstated and continued. Since that contract is cost-based, such does not preclude the hospitals from receiving increased reimbursement during the "cooling-off period".

47. In the event a new contractual arrangement is finally achieved between the Plan and the terminating hospitals, Public Act No. 94 requires that such be made retroactive. This treatment would merely continue what has been the past practice of the Philadelphia Plan and routinely approved by the Insurance Department. Indeed, as shown by the DVHC counsel's letter attached as Exhibit 29, retroactivity has always been a hospital demand, and in the referenced letter is made a condition precedent to settlement.

48. The contracts between Pennsylvania Plans and member Hospitals, as previously indicated, are based on accounting principles requiring the actual cost of providing health care to Subscribers be reimbursed by the Plan. Since this arrangement necessarily requires an estimate of future costs if the hospital is to realize essential cash flow, the 1971 Agreement provides in Section 18 for the submission of budgets. These estimates are then reviewed by the Plan's Staff following the procedure described in Exhibit 30. After the budgeted costs are agreed upon by

the Plan and hospital, an interim rate is developed based on the expected number of inpatient days projected for the fiscal period.

49. Since interim payments are made at the time a billing is presented to the Plan following a Subscriber discharge, there is, of course, some lag in payment. In order to reduce this receivable and the hospital's accompanying need for financing, the 1973 Agreement adopted an extensive advance program. This permits any Member Hospital to draw an interest-free advance equal to 15 days of anticipated reimbursement. The hospitals may also request a further 15 day advance, but interest on that sum will be charged by the Plan.

50. As of the end of each fiscal quarter, the hospital submits actual cost reports to the Plan. Based on this experience the interim rate may be adjusted, both retroactively and prospectively. Following the end of a fiscal year, final settlement is made based on actual cost as verified by independent certified public accountants and Subscriber usage for the period.

51. The 1973 Agreement provides that the Plan pay only costs incurred in providing patient care, and then only that portion represented by the ratio of Subscriber usage to total usage by all patients. Thus, any "loss" incurred as a result of services rendered free-care patients, "courtesy" allowances, or on account of services not related to patient care, such is not reimbursed by the Plan.

52. In the event any dispute arises under the 1973 Agreement, provision is made for final judicial review. Indeed, since the expense of legal representation, even that in matters involving Blue Cross, is generally a cost of doing business, the Plan reimburses the litigating hospital for the Blue Cross share of this expense.

53. The per diem costs, actual and project, for Philadelphia area hospitals have exhibited a dramatic rise in recent years. As shown in the chart attached as Exhibit 31, this cost has risen from $29.27 in 1964 to $117.83 for 1974. Importantly, this cost is projected to reach $201.25 in 1977. Clearly, without some form of limitation, be it contractual or regulatory, the cost of patient care will soon outstrip the means of many individuals. The 1971 and 1973 Agreements were instrumental in holding down costs, and as shown by Exhibit 32, worked to reduce the number of in-patient days by means of improved utilization review, provided penalties for medically unnecessary procedures and contained other consumer-oriented measures. However, with the removal of these contractual controls, costs and length of stay can again be expected to soar.

54. The Pennsylvania General Assembly has recognized the significant impact of rising hospital costs and has considered over the past few years several bills designed to establish direct regulation over hospital rates. Representative copies of these Bills are attached as Exhibit 33.

55. Regulation of hospital rates is not unique nor novel as the neighboring state of New Jersey, where the Philadelphia Plan currently contracts with a number of hospitals, has adopted legislation whereby the Departments of Health and Insurance mutually develop the rates which hospitals may charge Blue Cross Plans. A copy of the pertinent part of this regulatory statute is attached as Exhibit 34.

56. The fact that the hospital plaintiffs in this action are non-profit institutions does not exempt them from regulation by the Commonwealth for only the Pennsylvania Hospital, a Member Hospital, has claimed exemption from the power of the General Assembly pursuant

to the Nonprofit Corporation Law of 1972 (15 Pa. C.S. § 101(c)) by filing a certificate of nonacceptance of the Constitution of Pennsylvania under the Registry Act of 1966 and related legislation.

57. In sum, the Pennsylvania Plans, lacking direct governmental authority to limit hospital cost, have traditionally negotiated cost limitations and quality controls into their contracts with Member Hospitals. These controls are the product of collective bargaining and represent a substantial value for Subscribers. The Pennsylvania Legislature recognizes the success that the Plans have achieved in this voluntary process and encourage this form of development by only indirectly regulating hospital rates, that is, through Insurance Department approval of hospital contracts. However, if this bargaining process is no longer viable, hospital rate setting regulation may be required.

58. Public Act No. 94 does not alter the traditional contractual situation between Pennsylvania Blue Cross Plans and Member Hospitals. Rather, it recognizes their essential relationship and opts for its continuance. If the Insurance Department is finally unsuccessful in bringing the parties together, the hospitals will nevertheless receive full reasonable cost for their service rendered Subscribers (determined by a court, if necessary) during the "cooling off" period—no profit, but yet no loss attributable to that business.

/s/ BRUCE TAYLOR

Bruce Taylor

(Oath and Jurat Omitted in Printing)

(title omitted in printing)

ANSWER OF DEFENDANTS BLUE CROSS OF GREATER PHILADELPHIA, ROBERT P. KANE, ATTORNEY GENERAL, AND THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA TO PLAINTIFFS' AMENDED COMPLAINT

1. The averment of paragraph 1 concerning the position of plaintiff Paul I. Guest is admitted. The defendants are without knowledge or information sufficient to form a belief as to the truth of the remaining averments of paragraph 1 and, therefore, deny the same. In any event, the averments of the last and third to last sentences of paragraph 1 state conclusions of law for which no answer is required.

2. The averments concerning the identity of the answering defendants Kane and the Insurance Department are admitted. The averments of the next to the last sentence of paragraph 2 concerning Blue Cross are denied as stated. The remaining averments of paragraph 2 state conclusions of law and, therefore, no answer is required.

3. The averments of paragraph 3 either state conclusions of law or merely explain the nature of the action and, therefore, no answer is required. Nevertheless, it is denied that the plaintiffs are entitled to either declaratory judgment or injunctive relief against any of the defendants.

4. The averments of paragraph 4 are denied insofar as they apply to defendant Blue Cross.

5. The averments of paragraph 5 state a conclusion of law and, therefore, no answer is required.

6. The averments of paragraph 6 state conclusions of law and, therefore, no answer is required. The Act speaks for itself.

7. The averments of paragraph 7 state conclusions of law and, therefore, no answer is required. The Act speaks for itself.

8. The averments of paragraph 8 insofar as they relate to Blue Cross or to any of its contracts are denied as stated. In any event, the contract referred to in paragraph 8 with respect to Blue Cross speaks for itself. The defendants are without knowledge or information sufficient to form a belief as to the truth of the remaining averments of paragraph 8 and, therefore, deny the same.

9. The averments of paragraph 9 are denied as stated. In any event, the averments of paragraph 9 state conclusions of law, and therefore, no answer is required. Furthermore, the contracts referred to therein speak for themselves.

10. The averments of paragraph 10 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 10 are denied.

COUNT I

11. Paragraphs 1 through 10 of this Answer are incorporated herein by reference.

12. The averments of paragraph 12 state conclusions of law and, therefore, no answer is required. The Act speaks for itself.

13. The averments of paragraph 13 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 13 are denied.

14. The averments of paragraph 14 state conclusions of law and refer to contracts which speak for themselves and, therefore, no answer is required. Furthermore, the defendant Blue Cross is without knowledge or information sufficient to form a belief as to the truth of the averments concerning the contracts referred to in paragraph 14 to which it is not a party and, therefore, denies same.

15. The averments of paragraph 15 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 15 are denied.

16. The averments of paragraph 16 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 16 are denied as stated.

17. The averments of paragraph 17 state conclusions of law and, therefore, no answer is required. The contract referred to therein speaks for itself. Nevertheless, the averments of paragraph 17 are denied as stated.

18. The averments of paragraph 18 are denied.

19. The averments of paragraph 19 are denied.

20. The averments of paragraph 20 are denied.

COUNT II

21. Paragraphs 1 through 10 of this Answer are incorporated herein by reference.

22. The defendants are without knowledge or information sufficient to form a belief as to the truth of the averments of the first sentence of paragraph 22 and, therefore, deny same. The averment of the second sentence

states a conclusion of law and, therefore, no answer is required. The Act speaks for itself.

23. The answer to paragraph 16 is incorporated herein by reference.

24. The averments of paragraph 24 are denied.

25. The answers to paragraphs 11 through 15, and 17 through 20 of the complaint are incorporated herein by reference.

26. The averments of paragraph 26 are denied.

COUNT III

27. Paragraphs 1 through 26 of this Answer are incorporated herein by reference.

28. The averments of paragraph 28 state conclusions of law and, therefore, no answer is required.

29. The averments of paragraph 29 state conclusions of law and, therefore, no answer is required. Nevertheless, they are denied.

30. The averments of paragraph 30 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 30 are denied.

31. The averments of paragraph 31 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 31 are denied.

32. The averments of paragraph 32 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 32 are denied.

33. The averments of paragraph 33 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 33 are denied.

COUNT IV

34. Paragraphs 1 through 33 of the Answer are incorporated herein by reference.

35. The averments of paragraph 35 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 35 are denied.

36. The averments of paragraph 36 state conclusions of law and, therefore, no answer is required. Nevertheless, the averments of paragraph 36 are denied.

COUNT V

37. Paragraphs 1 through 26 of the Answer are incorporated herein by reference.

38. The letter referred to in paragraph 38 speaks for itself and, therefore, no answer is required.

39. The averments of paragraph 39 are denied as stated.

40. The notice published by the defendant Blue Cross speaks for itself, and is within the protection of Amendment I of the Constitution of the United States.

41. The answer to paragraph 30 of this Answer is incorporated herein by reference.

42. The correspondence referred to in paragraph 42 speaks for itself and, therefore, no answer is required. In any event, the averments are denied.

43. The averments of paragraph 43 are denied.

44. The averments of paragraph 44 are denied.

45. The answer of paragraph 32 of this Answer is incorporated herein by reference.

46. The averments of paragraph 46 are denied.

SEPARATE DEFENSES OF ALL DEFENDANTS FILING THIS ANSWER

1. The plaintiffs have withdrawn their request for temporary restraining orders.

2. The plaintiffs are not entitled to any injunctive relief, preliminary or permanent, against any of the defendants for, among other reasons, because the Act is constitutional.

3. The plaintiffs have failed to state a claim upon which relief can be granted with respect to the defendant Blue Cross.

4. The plaintiffs lack clean hands and have failed to do equity.

SEPARATE DEFENSES OF DEFENDANT ROBERT P. KANE, ATTORNEY GENERAL

5. The Attorney General does not intend to institute criminal proceedings under this Act so long as the constitutionality of the Act is undecided.

6. There is presently no case or controversy between the plaintiffs and the defendant.

SEPARATE DEFENSES OF DEFENDANT THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA

7. This suit is barred by Amendment XI to the Constitution of the United States.

8. There is presently no case or controversy between the plaintiffs and the defendant.

/s/ DENIS V. BRENAN

DENIS V. BRENAN

/s/ WILLIAM E. ZEITER

WILLIAM E. ZEITER
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Attorneys for Defendant
Blue Cross of Greater Philadelphia

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/s/ HOWARD M. HOLMES

HOWARD M. HOLMES
206 State Office Building
Philadelphia, Pa. 19130
Attorney for Defendants
Robert P. Kane, Attorney General
The Insurance Department of the
Commonwealth of Pennsylvania

(Certificate of Service Omitted)

SUPPLEMENTAL AFFIDAVIT

PAUL I. GUEST, being duly sworn according to law deposes and says:

1. That he is a plaintiff in this case, a member of the Bar of this Court, the Chairman of the Delaware Valley Hospital Council ("DVHC"), and the President of Methodist Hospital, also a plaintiff in this action; that he is one of two negotiators representing the Delaware Valley Hospital Council in negotiations with Blue Cross of Greater Philadelphia; that he makes the following statement which is based upon his own personal knowledge in reply to certain allegations contained in the Affidavits of Bruce Taylor, President of Blue Cross:

2. In Paragraph 26 of Mr. Taylor's Affidavit, he indicates that upon assuming the office of the Insurance Commissioner, William Shephard issued a news release (attached thereto at Exhibit 16), advising that the control measures previously mandated would be continued. While it is true that Commissioner Shephard originally issued the release, he, on behalf of the Insurance Department and Governor Shapp subsequently changed this position on the so called "ceiling" and "plus factor" immediately after February 14, 1975, when Governor Shapp and Senator Schweiker met with the Hospital and Blue Cross representative and trustees of many of the hospitals involved.

3. Subsequent to this meeting, representatives of the Governor—primarily, Commissioner Shephard, Gerald Mongelli, Deputy Insurance Commissioner, and Robert Archer of the Insurance Department—sought to mediate the contract dispute between the hospitals and Blue Cross. Archer, Mongelli, and Shephard met numerous times with

representatives of Blue Cross and the Hospitals. In these meetings, the Insurance Commissioner indicated that the Department's position had changed and that the Department would approve a contract without a ceiling and one including a "plus factor" which was urged as necessary to help the hospitals alleviate some of the substantial losses resulting from unreimbursed patient care and unfunded operating growth need.

4. The idea of a "plus factor" in the nature of a percentage of allowable costs is not a novel provision in Blue Cross contracts. The Agreement between Blue Cross and the Hospitals dated July 1, 1967 (attached to the original Taylor affidavit at Exhibit 13), contained, *inter alia*, the following principles:

"1-10 Allowance in Lieu of Specific Recognition of Other Costs

Principle

"In lieu of specific recognition of other costs in providing and improving services, an allowance amounting to two (2) percent of allowable costs (with the exception of interest expense and the allowance under this principle) is includable as an element of reasonable cost of Covered Services.

Application

"Difficulty in measurement, lack of adequate data and other considerations have precluded specific recognition of various elements which are germane to costs of Covered Services for Subscribers. Moreover, although the methods to be utilized by Providers for determining the actual cost of Covered Services provided to Subscribers are the best available, there is some lack of precision in methods for determining

costs at the present stage of development of cost finding which represents a contingency for which recognition is appropriate. It is the established practice of a significant number of large third-party purchasers to include in payment for costs of services a factor in the form of an allowance to cover various elements not specifically recognized or not precisely measured.

"1-11 Allotment for Development Requirements Principle

"In partial recognition of the financial needs of the Provider for certain developmental expenses which have not been provided for under these Principles of Reimbursement for Provider Cost, an allotment amounting to one (1) percent of allowable cost (with the exception of interest expense and the allotment under this principal) is included as an element of reasonable cost of Covered Services.

Application

"The amount of reimbursement received by the Provider under this allotment shall be used by the Provider for the sole purpose of meeting cost which may be incurred by the Provider for purchasing equipment (Types I and II Hill-Harris) for the improvement or maintenance of patient care standards. Any amount which is not used for this purpose during the course of the year shall be available for such use in subsequent years."

Principles 1-10 and 1-11 were both deleted by the Amendments to the 1967 agreements which were effected July 1, 1970, and which added in lieu of these principles incentive payments for use of inpatient provider facilities, cost containment, and cost reduction projects.

The agreement of July 1, 1971, negotiated after the forced termination of the 1967 agreement as modified in 1970, resulted in the elimination of all incentive payments.

5. Meetings continued through July with the Insurance Department and eventually with the Governor and other members of his staff and cabinet; throughout these meetings, the inclusion of a "plus factor" was presumed, and the primary issue was how much the "plus factor" would be. Finally, in all-day meetings with the Governor and his representatives on August 2nd and 3rd, 1975, all the basic issues were resolved, except the amount of the "plus factor". The so called "quality control standards" were all resolved. However, when agreement could not be reached on the amount of the "plus factor," Governor Shapp signed Act 94 and the meetings were discontinued. As a result of Act 94, no negotiations are now taking place.

6. On August 8, 1975, at a meeting arranged by Insurance Commissioner Shephard to discuss the implementation of Act 94, the Blue Cross officials, Bruce Taylor, President, and Jerome Lynch, Executive Vice President, refused to discuss the Implementation of Act 94 claiming they did not know the meeting had been called for that purpose and walked out.

7. Immediately following the "walk out", the DVHC negotiators and the attorney for Blue Cross, through the efforts of and in the presence of Mr. Mongelli, Deputy Insurance Commissioner, reached complete agreement on a package settlement which was acceptable to the Insurance Department and which they agreed to recommend to their respective clients.

8. The proposed agreement which was approved by the Insurance Department contained a "plus factor". It was presented to the hospitals by their negotiators and

was accepted. The Blue Cross Board of Directors rejected it.

Contrary to the statements of Mr. Taylor in paragraph 44, the reason no agreement was reached was not that the "DVHC negotiators steadfastly insisted upon a profit percentage and abandonment of quality controls as the price of a contract." Blus Cross, the Hospitals and the Insurance Department had agreed upon the "quality control standards." Agreement was not reached because the Blue Cross Board would not agree to the amount of the "plus factor" which was acceptable to the Hospitals and the Insurance Department. Blue Cross had already agreed to the principle of a "plus factor" or what Blue Cross now refers to as a "profit percentage"; it was only that Blue Cross would not agree to the "price."

9. Exhibit 33 to the original Taylor affidavit is a letter from Frank H. Abbott, attorney for DVHC, to Commissioner Shephard dated July 8, 1975, which represents the Hospitals' position as of July 3, 1975, after we first met with the Governor. It was prepared at the Governor's request so that he would have a statement of the remaining issues. [Even though Governor Shapp had requested both parties to put in writing the remaining issues and to state their positions on each of them, to my knowledge Blue Cross did not submit in writing a copy of its position.] The Hospitals subsequently agreed to a reduction of the 7½% figure referred to for unreimbursed patient care and operating growth need. The agreement which was recommended by the attorneys for Blue Cross and the Hospitals, approved by the Insurance Department on August 8, 1975 and accepted by the Hospitals, contained a figure of 4% per year for each of three years, plus one percent considered to be interest on funds withheld during the contract dispute. The "pot" was to be distributed

among the hospitals based upon their unreimbursed patient care and operating growth needs. It was not to be a flat payment of 4% to each hospital. This agreement was rejected by the Board of Directors of Blue Cross.

10. Contrary to the implication in paragraphs 34 and 35 of Mr. Taylor's Affidavit, the Delaware Valley Hospital Council did not refuse to accept a contract negotiated by the proprietary hospitals, but on the contrary offered to accept the contract if it contained *all* of the provisions in the proprietary hospital agreement, *i.e.* those dealing with reimbursement as well as the cost containment measures. Blue Cross at all times refused to offer the entire proprietary hospital agreement to the non-profit hospitals.

11. Contrary to the statement in paragraph 40 of Mr. Taylor's Affidavit, the Philadelphia medical school hospitals did not "abandon the DVHC position." The Medical School Hospitals remained in the Delaware Valley Hospital Council, but negotiated and executed a separate agreement with Blue Cross principally because of governmental pressure in the form of threats to cut off their state subsidies which far exceed the loss they would sustain under any Blue Cross contract. The Medical School agreement contains a provision which will give the Medical School Hospitals the benefit of any "better" contract negotiated by the Non-Medical School Hospitals with Blue Cross, and this is the main reason the Blue Cross Board did not accept the agreement recommended by its attorney and the Insurance Department: the Medical Schools—whose daily rate is more than 50% higher than that of the other DVHC hospitals—would have received the same 4% "plus factor."

12. In paragraph 53 of his affidavit, Mr. Taylor argues that contractual or regulatory controls are necessary to curb soaring hospital costs, necessarily implying

that there is no legitimate reason for these cost increases. However, in pressing for a rate increase at the Insurance Department Public Hearing on March 17, 1971, Mr. Taylor made a statement from which the following quotation is taken:

> "If the protection of public interest is to be expanded, then it must be through the establishment of specific involuntary controls over the costs which a hospital incurs. Before discussing any such changes, however, one fact should be recognized. The overwhelming cause of rising hospital per diem costs in the past five years has been the increases in the pay scale of hospital employees. As we have said on prior occasions, hospital employees were substantially underpaid and much of this increase has been necessary to bring them to a level comparable to other members of our nation's working force. The extent to which hospital employees receive further wage increases beyond the level now existing is a matter for hospital management and labor negotiations. Blue Cross is not a participant in that collective bargaining operation and has no legal authority to make itself a party. Moreover, we have no expertise on the wages of hospital employees."

13. In that same statement to the Insurance Department Mr. Taylor also argued persuasively against the position which Blue Cross now advances that Act 94 is justified as rate-making legislation which, in effect, delegates the setting of rates to the Blue Cross organization. I again quote from Mr. Taylor's statement of March 17, 1971:

> "• • • Before discussing the implementation of these various possibilities by Blue Cross, certain general considerations need to be recognized, however.

> "First, these changes are unlikely to be wrought through voluntary changes in the Blue Cross-Hospital contract. Our past experience makes it clear that hospitals simply won't agree to such changes on a voluntary basis. To inflict such terms on the hospitals will remove many of them as providers under our contracts. As a result our subscribers will be restricted to non-member indemnity benefits; a serious burden on them.
>
> "Second, Blue Cross regulation of hospital cost raises serious internal problems. Hospitals vary infinitely and general standards applicable to all cannot be fixed fairly. Differences in plant, in types of cases, types of medical practice and many other facts affect their cost. To consider these multiple factors properly would require a major expansion of the Blue Cross staff. Moreover, Blue Cross, even with an expanded staff, is not peculiarly fit for this decisional process. It has no expertise in many of these areas. Moreover, as the payor, Blue Cross decisions could be biased by its interest in reducing its own payments.
>
> "Third, decisions on most areas of hospital cost control will have profound influences on the entire health care delivery system. To suggest that such decisions should be exclusively in the hands of a single purchaser of health care is clearly foolhardy. Blue Cross personnel can claim no infallibilty in this field, nor even special training, where medical practice and hospital procedures are involved. Obviously and without false modesty this role should not be exclusively ours.
>
> "Fourth, legal authority is required to produce involuntary changes in the health care system as it exists today. The changes must be made uniformly in

all hospitals and among the entire medical profession; they must be backed by the financial efforts of the community; and they must have the support of the public in their capacity as patients as well as subscribers to Blue Cross. Such uniformity can only come through governmental supervision based on law, not the indirect pressure of changing Insurance Commissioners through a variety of Blue Cross entities.

"Finally, it must be recognized that Blue Cross is not the only payor in the health care field and whatever it may recommend cannot possibly prevail if Medicare and Medicaid follow other practices. To date neither the state nor the federal government has shown any capacity to provide realistic control of hospital costs.

"So much for general principles."

14. In support of the Motion for Summary Judgment of Plaintiffs and Plaintiffs-Intervenors, we originally submitted the affidavit of Mr. Edward Armstrong, the Administrator of Jeanes Hospital, to substantiate the fact that even as applied to a hospital with a relatively small indigent patient population and one which had experienced no unusual problems under its contract with Blue Cross, the effect of Act 94 would be to impose upon that hospital a loss of more than $50,000 a year. (Affidavit of Edward J. Armstrong, paragraph 10).

Nowhere in Mr. Taylor's Supplemental Affidavit is it disputed that there are costs incurred by Jeanes and the other hospitals which are simply not reimbursed by Blue Cross. Instead the affidavit details other sources of income available to Jeanes which can be used to offset the amount by which Blue Cross fails to reimburse the hospital its actual costs of providing service. While the legal distinction between stealing from a rich man and stealing from a poor one is not readily apparent, we are submitting herewith additional Supplemental Affidavits to document the fact, seemingly conceded by Blue Cross, that Jeanes Hospital is among the most financially secure members of plaintiff hospital class.

/s/ PAUL I. GUEST

Paul I. Guest

(Oath and Jurat Omitted in Printing)

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA } *ss:*

JOSEPH A. WILLIAMSON, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the President of the Delaware Valley Hospital Council ("DVHC"), plaintiff-intervenor in this case, a non-profit association of sixty-seven non-profit hospitals in Southeast Pennsylvania, located at 311 South Juniper Street, Philadelphia, Pennsylvania 19107. DVHC was and is the bargaining representative of those members of plaintiff hospital class which are signatories to the Delaware Valley Agreement, as it is denominated in the Complaint, in their contract negotiations with Blue Cross.

2. That in this position which he has held for two years, he is required to be knowledgeable about the terms and usage of the Delaware Valley Agreement, its affect generally on the hospitals to which it applies, and its affect on individual hospitals in the context of each hospital's unique patient population and financial situation. The impact of the Delaware Valley Agreement on selected hospitals is reflected in the affidavits attached hereto as exhibits.

3. That under the Principles of Reimbursement contained in the Delaware Valley Agreement, Blue Cross does not recognize and will not reimburse the hospitals certain expenses although it is clear that these are expenses incurred regularly as a necessary part of the hospitals' performance of their duties to the public. Chief among these expenses which Blue Cross will not "allow" are the

costs of unreimbursed patient care, which includes treatment of indigents, charity allowances, and bad debts as detailed below.

4. That while Blue Cross does undertake to pay bad debts resulting from its subscribers' failure to pay the relatively small deductible or co-pay amounts specified in their subscriber contracts, it assumes no responsibility for bad debts incurred by its subscribers once their coverage has expired. Thus, a substantial portion of the hospitals' costs of covering bad debts—no part of which is borne by Blue Cross—is attributable to costs expended in treating patients who entered the hospital as Blue Cross subscribers, but who continued to receive services after their coverage had expired, charges for which proved uncollectible. In calculating the pro rata share of costs of unreimbursed patient care which ought to be borne by Blue Cross, the hospitals represented by the attached affidavits may not have made consistent adjustments for payments by Blue Cross to reimburse subscriber defaults in paying deductible or co-pay amounts. However, in no case would such an adjustment materially alter the magnitude of Blue Cross' underpayments to the hospitals.

5. That there is no hospital which did not suffer operating losses under the Delaware Valley Agreement—and will not now suffer losses if Act 94 is effective to reinstate that Agreement—as a result of Blue Cross' failure to pay on behalf of its members, in common with all other private paying patients, a share of the hospital's costs of unreimbursed patient care in the same proportion which Blue Cross covered charges bear to total charges entered by the hospital against its patients.

6. That the amount of money properly allocable to Blue Cross subscribers, but which Blue Cross will not reimburse the hospitals under the Delaware Valley Agree-

ment, varies according to each hospital's individual patient mix. Where the indigent patient population is relatively small as at Jeanes Hospital, the extent of this loss can be as small as $50,000 a year (Affidavit of Edward J. Armstrong, paragraph 10). On the other hand, hospitals which must expend far greater amounts in providing unreimbursed patient care suffer proportionally greater losses as a result of the limitations in the Blue Cross payment formula. If Blue Cross paid its full share of hospital costs, Mercy Catholic Medical Center ("MCMC") would have received an additional $655,624 from Blue Cross for fiscal year 1974 (Affidavit of Ragnar W. Anderson attached hereto as Exhibit "B", paragraph 6); in the same year, Blue Cross would have paid Presbyterian—University of Pennsylvania Medical Center ("PUPMC") an additional $203,400 (Affidavit of Carl L. Mosher attached hereto as Exhibit "C", paragraph 6); for fiscal year 1975, the amount representing Blue Cross underpayment to Episcopal Hospital is $337,235 (Affidavit of Fred G. Clark, attached hereto as Exhibit "A", paragraph 7).

7. That for a non-profit hospital, this loss necessarily translates into net operating loss except to the extent that the hospital can surcharge patients who are self-insured or covered by commercial insurers and thus reduce the loss represented by that share of unreimbursed costs of patient care which is not paid by Blue Cross and other third party payers. While in most cases it is not possible to impose so large a financial burden on a relatively small segment of the patient population (Exhibit A, paragraph 8), the need to reduce losses by surcharging private paying patients has resulted in situations where private insurers, which normally pay full charges, are paying 40% more than Blue Cross for comparable services (Exhibit B, paragraph 7).

8. That while some hospitals have available unrestricted endowment fund income which can be applied to reduce the hospital's net operating loss, others do not have such other sources of income (Exhibit B, paragraph 10). Even where such income is available, it is often inadequate to offset operating losses (Exhibit A, paragraph 9; Exhibit C, paragraph 7).

9. That in the case of Episcopal Hospital, it was necessary in fiscal years 1974 and 1975, and is again necessary in 1976, to cut into endowment fund principal to the extent permitted by the law governing non-profit corporations in order partially to reduce net losses. Episcopal Hospital was required to reduce its endowment fund principal by close to $1,000,000 in these three years alone (Exhibit A, paragraph 10).

10. That to the extent that endowment fund income is simply not available or is inadequate to balance operating losses resulting from unreimbursed patient care, the hospitals must utilize money which ought properly to be funded from depreciation allowances on patient charges. In order to show a break even figure on operating expenses for fiscal year 1975, Episcopal Hospital would have had to use its entire depreciation reserve for that year had it not chosen instead to dip into its endowment fund principal; even after borrowing from the principal, Episcopal still depleted nearly two-thirds of its depreciation reserve to make up operating losses. (Exhibit A, paragraph 11). In fiscal year 1974, MCMC used virtually all of its depreciation reserve to meet its operating needs (Exhibit B, paragraph 9).

11. That the hospitals' shortage of working capital resulting from the failure of Blue Cross to reimburse the hospitals their share of the costs of unreimbursed patient care is exacerbated by the delay suffered by the

hospitals in receiving payments from Blue Cross. While Mr. Taylor suggests that this problem is obviated by Blue Cross' provision of an advance equal to 15 days of current costs and its willingness to provide an additional 15 day advance on which interest is charged (Supplemental Affidavit of Bruce Taylor, paragraph 70), in many cases, the actual time lag experienced by the hospitals between time of billing and receipt of payment far exceeds 15 days. Thus, MCMC regularly experiences average delays in payment of more than 40 days or the equivalent of half a million dollars more than is contemplated by the 15 day advance program (Exhibit B, paragraph 8).

12. That in addition to "normal" delays in receipt of Blue Cross payments, whenever there is a dispute between a hospital and Blue Cross as to the amount of reimbursable costs, it is the hospital which pays the cost of the delay and may ultimately be forced to compromise a legitimate claim because it can not afford to defer payment indefinitely and still continue to operate. PUPMC, for example was forced to accept payment from Blue Cross for fiscal year 1970 of only 61% of its allowable costs. It did so finally in January of 1973, in order to recover at least some part of the close to one million dollars in challenged costs for that year and fiscal year 1971 which Blue Cross was holding back. The hospital received no interest whatsoever on this money. (Exhibit C, paragraph 9).

13. That, as a result of the inadequacy of Blue Cross formula reimbursement and the delays imposed by Blue Cross on the hospitals in receiving payments, some hospitals are required to borrow money simply in order to meet their operating expenses (Exhibit C, paragraph 10).

14. That in those cases where short term borrowing is avoided by a hospital's use of depreciation reserves to

meet current operating expenses, the need to borrow money to continue operations is simply pushed forward to the time when the hospital has to replace its plant or equipment and lacks the reserve which would otherwise be available for that purpose. (Exhibit B, paragraph 9).

15. That, in addition to the fact that the depreciation factor which is recognized by Blue Cross must, in practical effect, be used by the hospitals to make up unreimbursed costs which Blue Cross does not recognize, the Blue Cross reimbursement formula under the Delaware Valley Agreement does not make any provision for the hospitals' operating growth needs. This is in contradistinction to the fact that Blue Cross contracts with hospitals in other states do include a so-called plus factor to provide for needed expansion or improvement of the hospitals' plants and equipment; that such a plus factor was included in the 1967 contract between Blue Cross and the hospitals represented by DVHC; that the Insurance Department and the Governor recommended the inclusion of a plus factor in attempting to mediate the contract dispute between the hospitals and Blue Cross; and that a contract negotiated by the attorneys for the hospitals and Blue Cross, approved by the Insurance Department, accepted by the hospitals, but rejected by Blue Cross, included such a plus factor.

16. That, in order to meet their operating expenses in spite of the fact that, under the Delaware Valley Agreement, Blue Cross simply does not pay its full share of these expenses, the hospitals are being forced to use funds intended and ultimately needed for other expenses less immediate perhaps, but no less necessary to the hospitals' continued financial viability over time.

17. That if all its patient charges were reimbursed on the same basis as those of Blue Cross subscribers, there

is no hospital which would not in time be threatened with insolvency.

The foregoing is true and correct to the best of my personal knowledge.

/s/ JOSEPH A. WILLIAMSON
Joseph A. Williamson

(Oath and Jurat Omitted in Printing)

SUPPLEMENTAL AFFIDAVIT OF BRUCE TAYLOR PRESIDENT OF BLUE CROSS OF GREATER PHILADELPHIA

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA *ss:*

BRUCE TAYLOR, being duly sworn according to law, deposes and says that he is President of Blue Cross of Greater Philadelphia, one of the defendants in the foregoing action; that as such he is duly authorized to, and does make this supplemental affidavit on its behalf; that he makes this supplemental affidavit and made the affidavit dated October 7, 1975 which was previously filed of record in this action on personal knowledge; and that the facts set forth in this supplemental affidavit and in his affidavit dated October 7, 1975, are true and correct. Further, deponent says in reply to the Affidavit of Edward J. Armstrong, Administrator of Jeanes Hospital, dated October 6, 1975, that:

59. The reimbursement paid Jeanes Hospital, as well as every other Pennsylvania non-profit hospital which contracted with Blue Cross of Greater Philadelphia under the 1967, 1971 and 1973 Agreements was based on the same cost accounting principles as utilized by the federal government in computing Medicare payments. These procedures, which were outlined in my October 7, 1975 Affidavit (See ¶ 24), require that all legitimate costs associated with the treatment of Subscribers be paid by the Plan. These costs include not only payroll, medicine, supplies and meals, but also encompass maintenance expenses, depreciation, and interest on borrowed funds. Exhibit A to the 1971 Agreement details these various costs and incor-

porates by reference the appropriate Medicare rules, regulations and interpretations which provide the detail procedures utilized by independent certified public accountants in fixing final payments.

60. The Medicare program is based on the principle that the costs attributable to a given patient should be borne by that patient or the third-party payor responsible for reimbursing the hospital for services rendered that patient. In developing the extensive procedures necessary to accomplish this result, Congress, and the Social Security Administration, borrowed substantially from the "Principles of Payment for Hospital Care" (the "AHA Principles") approved by the American Hospital Association ("AHA") in September, 1953, a copy of which document is attached as Exhibit 35. Jeanes Hospital and the other hospital parties to the 1967 and 1971 Agreements are members of the American Hospital Association.

61. Although Mr. Armstrong suggests in Paragraph 6 of his Affidavit that the Plan should bear the costs attributable to "providing care to indigents", "uncollectible amounts other than those of Blue Cross subscribers, providing charity allowances" and underwriting all "educational and research activities", the AHA Principles state such is improper. Indeed, an analysis of the comparable sections of Exhibit A to the 1971 Agreement and the AHA Principles shows substantial identity. (*e.g.*, bad debts, charity and courtesy allowances—Agreement § 1.3, Principles § 2.304; educational activities—Agreement § 1.4, Principles § 2.302; and research—Agreement § 1.5, Principles § 2.301).

62. The ceiling on payments which was negotiated into the 1971 Agreement for fiscal years 1972 and 1973 was not an idea novel to the Plan. The AHA Principles specifically provide in Section 3.400 that, "Ceilings on the

amount of payment are not inconsistent with the principle of 'full costs' and may be established through conference between third-party agencies and contracting hospitals."

63. As a non-profit charitable institution, Jeanes Hospital, as well as all other hospitals represented by the DVHC, receives substantial charitable contributions and endowment income. These monies, to the extent they are not designated by the donor for specific operating expenses, are *not* deducted from the cost of running the hospital by the Plan or Medicare in determining reimbursable costs. (See, § 1.6 of Exhibit A, 1971 Agreement).

64. The certified financial statements prepared for Jeanes Hospital by its certified public accountants, Coopers & Lybrand, show that it realized $514,000 in 1973, and $454,000 in 1974 from investments and contributions. Indeed, when this amount was added to operating expenses, Jeanes Hospital realized net operating profit in 1973 of $303,560, and $284,945 in 1974. A copy of these financial statements is attached as Exhibit 36.

65. In addition to realizing substantial current income from endowments and contributions, Jeanes Hospital has a substantial investment portfolio which provides a steady income stream. As of June 30, 1974, the cost of this investment fund amounted to more than $1 million. Further, note 4 to the financial statements suggests that the continuing endowment income of which Jeanes Hospital is the beneficiary, permits it to obtain low cost loans. Importantly, any interest paid on such loans is recognized as a reimbursable cost by the Plan. Lastly, it should be noted that although the main building of Jeanes Hospital was contributed property, the Plan has paid depreciation on this plant thereby paying the Hospital for something which it never really purchased.

66. The state program of medical assistance for the poor, known as "Medicaid", provides a mechanism whereby hospitals may be reimbursed for medical services rendered indigent persons. Under this program, a hospital contracts with the Pennsylvania Department of Public Welfare on a cost basis which is similar to that utilized by the Plan and Medicare. However, Jeanes Hospital has historically disavowed involvement in such programs. An article published in the Evening Bulletin on September 29, 1961 quotes Mr. Manley C. Solheim, then Administrator of Jeanes Hospital, as stating its "Board of Directors does not believe in government subsidy." A copy of this article is attached as Exhibit 37. Further, a review of the most current listing published by the Pennsylvania Department of Public Welfare of hospitals participating in Medicaid indicates that Jeanes Hospital is not included in that program. A copy of this list is attached hereto as Exhibit 38. Thus, although Jeanes Hospital may be complimented for its steadfast refusal to accept government subsidies or payments intended to defray the cost of providing medical services to indigent persons, it is difficult to understand why, on the other hand, it desires to collect such a subsidy from the Blue Cross Subscribers.

67. Other hospitals, not as well supported as Jeanes Hospital or committed to a policy of non-government affiliation have actively participated in the Medicaid program. Based on a review of the listing attached as Exhibit 38, it appears that all of the other DVHC represented hospitals receive Medicaid payments.

68. In addition to the Medicaid program, a considerable number of hospitals receive substantial financial aid under the Hill Burton Act (42 U.S.C. § 291 *et seq.*) This legislation permits the Federal government to make monies available to hospitals for construction purposes.

As with any other contributed funds, although these are given directly by the taxpayers, the full cost of capital projects financed under Hill Burton are entitled to depreciation allowances over their useful life and such is a reimbursable cost.

69. Although hospital charges in the Greater Philadelphia area generally run about 20% over the cost of such care as reimbursed by the Plan and government third party payors under Medicare and Medicaid these payments do include factors significantly beyond a strict "barebones" cost. Further, of the three payments, the Blue Cross reimbursement is the highest, and based on recent changes in Medicare, the incremental difference will soon widen.

70. The 1973 Agreement contained an extensive procedure to ensure that all contracting hospitals are paid on a current basis. Under that accord, each hospital receives an advance equal to 15 days of current costs, and if it so requests, the Plan will make a further 15 day advance, although interest is charged on the second increment. Further, all hospitals are paid currently for Subscriber care utilizing a per diem rate calculated from the hospital's own budget. These per diem rates are adjusted quarterly utilizing the hospital's actual cost experience and at the end of each year are settled based upon a final audit conducted by independent certified public accountants to determine if there is any overage or underage in the payments. Thus, the hospital's working capital requirements due to the Blue Cross business are insignificant, if at all.

71. Since all hospitals which were parties to the 1973 Agreement are being paid currently under the procedure described in the foregoing paragraph, the enactment of Public Act No. 94 should have had no adverse affect upon

their financial integrity. Indeed, since Jeanes Hospital, as well as the other DVHC represented hospitals, have accepted retroactive payments in the past, the current situation is not substantially different. A copy of the signature page of the Jeanes Hospital 1971 Hospital Agreement indicating it was signed on May 15, 1972, although effective July 1, 1971, is attached hereto as Exhibit 39.

72. Paragraph 7 of Mr. Armstrong's affidavit states that "Blue Cross has directed Jeanes Hospital that unless it is willing to negotiate a new payment ceiling, *i.e.*, a percentage limitation over allowable costs for the previous year, it will be reimbursed in accordance with the ceiling limitation contained in a 1974 Agreement negotiated by Blue Cross with entirely different parties." In support of this baseless assertion, Mr. Armstrong refers to a letter dated September 19, 1975 addressed to Episcopal Hospital which is attached as Exhibit C to the Memorandum of Plaintiffs and Plaintiff's Intervenors in Support of Motion for Summary Judgment. (Subsequently copies of a substantially similar letter were forwarded to all DVHC represented hospitals under date of September 23, 1975.) The letter does not refer to final rates or the total reimbursement which the hospital will receive. Rather, since Public Act No. 94 reinstates the 1971 Agreement a limitation on interim rates is required. This matter was discussed at length between attorneys for the Plan and the DVHC hospitals. Indeed, in a letter addressed to Blue Cross counsel under date of September 26, 1975, Frank H. Abbott, Esquire, the DVHC solicitor, forwarded for comment a letter dated September 25, 1975 addressed to all DVHC represented hospitals wherein he advised them that the information requested in the Plan's letter of September 23, 1975 would have "no affect on final settlement". A copy of these letters is attached as Exhibit 40.

73. By letter dated October 6, 1975 from Dr. Howard W. Baker, Plan Vice President, to the Chief Executive Officer of each DVHC represented hospital, the Plan explicitly stated that the September 23, 1975 letter was intended to deal only with the establishment of interim rates and not affect final settlements which would be based on "full reasonable costs which, of course, as determined by the circumstances, might be greater or less than the interim rates." A copy of this letter is included with Exhibit 40.

74. A schedule setting forth the amount of the advances made by the Plan to the various DVHC represented hospitals is attached as Exhibit 41.

/s/ BRUCE TAYLOR

Bruce Taylor

(Oath and Jurat Omitted in Printing)

SECOND SUPPLEMENTAL AFFIDAVIT OF BRUCE TAYLOR PRESIDENT OF BLUE CROSS OF GREATER PHILADELPHIA

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF PHILADELPHIA } *ss:*

BRUCE TAYLOR, being duly sworn according to law, deposes and says that he is the President of Blue Cross of Greater Philadelphia, one of the defendants in the foregoing action; that as such he is duly authorized to, and does make this Affidavit on its behalf based on his personal knowledge; and that such statements are true and correct. Further, deponent says in reply to the Affidavits of Paul I. Guest, Chairman of the Delaware Valley Hospital Council and President of Methodist Hospital ("Guest Affidavit"), Joseph A. Williamson, President of the Delaware Valley Hospital Council ("Williamson Affidavit"), Fred G. Clark, Vice-President of Finance, Episcopal Hospital ("Clark Affidavit"), Ragnar W. Anderson, Acting Director of Fiscal Affairs and Controller of Mercy Catholic Medical Center, Fitzgerald Mercy Division ("Anderson Affidavit"), and Carl L. Mosher, President of Presbyterian-University of Pennsylvania Medical Center ("Mosher Affidavit"), that:

75. The Guest Affidavit contains a lengthy description of the negotiations between the DVHC represented hospitals and the Plan which is, in many respects, at variance with my recollection and understanding of those events and the positions of the various individuals and parties identified. However, as I believe the specifics of the negotiations are neither relevant nor material to the instant litigation, I have refrained from a seriatim response, but will in the following few paragraphs seek to clarify

certain factual matters upon which there can be no dispute.

76. Although the negotiations between the Plan and DVHC represented hospitals included discussions with regard to the feasibility of a "profit factor", such was always considered in the context of a settlement package which would necessarily include effective quality controls designed to preclude unnecessary services, facilities, or utilization which inflate hospital costs without improving patient care. Indeed, in the Insurance Department's Order and Adjudication at Docket No. R-75-9-22, dated October 16, 1975, with regard to the Plan's last rate filing, the Commissioner stated, "The Department is hopeful that a viable agreement will be reached [with the DVHC represented hospitals] in the reasonably immediate future which will encompass, among other things, appropriate methods of cost control and utilization review." Clearly, cost and quality controls have, and continue to be, a major concern of the Pennsylvania Insurance Department, the state regulatory agency which must approve any Blue Cross-Hospital contract. A copy of the referenced portion of the Order is attached as Exhibit 42.

77. Paragraph 4 of the Guest Affidavit cites Principle 1-10 of the 1967 Agreement as an example of a "plus factor" which appeared in previous Blue Cross-Hospital accords. Unfortunately, the affiant does not explain the reason for the elimination of this provision which was originally copied verbatim into the 1967 Agreement from the then existing Medicare Regulations. At the initiation of the Medicare program, the U.S. Department of Health, Education and Welfare (HEW) believed the untried nature of the cost finding methodology might preclude or fail to pick up certain true patient care costs, hence the special allowance and allotment. However, this fear proved unfounded, and HEW amended the Medicare

Regulations (20 C.F.R. § 405.428) on June 27, 1969 to eliminate, as an element of reasonable cost, the allowance in lieu of specific recognition of other costs that had been afforded by Principle 1-10. Following this change, the 1967 Agreement, with the acquiescence of all contracting hospitals, was amended to reflect this change in Medicare Regulations.

78. The Guest Affidavit alleges in paragraph 11 that considerable governmental pressure was exerted on the medical school hospitals to force their abandonment of the DVHC position. This assertion is clearly at odds with the hospitals' own published statement attached as Exhibit 24 to my prior Affidavit. Further, since Mr. Guest fails to provide any supporting evidence for his allegation, it would seem improper for inclusion in what purports to be a factual affidavit. Moreover, the Guest Affidavit fails to reflect the fact that the 1974 Agreement was negotiated with, and executed by, not only all the medical school hospitals in Philadelphia, but also a number of community hospitals which were and are members of the DVHC. A listing of the several hospitals which have executed the 1974 Agreement is attached as Exhibit 43.

79. The sections of my testimony before the Insurance Department on March 17, 1971 which are quoted in paragraphs 12 and 13 of the Guest Affidavit are obviously taken from the context of my full presentation and therefore are somewhat misleading. In order to cure this deficiency there is attached hereto as Exhibit 44, a complete copy of the transcript made at those hearngs, which includes the full text of my remarks.

80. In reviewing Exhibit 44 it should be clear that while there are numerous costs over which a hospital has little, if any control, there are also many areas where considerable cost savings could be achieved and patient care upgraded by the initiation of more efficient methods.

Since, as I previously testified, many of these areas involve the relationships between hospitals as a group, as well as the willingness of individual institutions to abandon old methods, success would be more predictable through direct regulation than via contract negotiations. Initially it appeared my apprehension was well founded as the negotiations preliminary to the final approval of the 1971 Agreement were often marked by little progress and heated exchanges. However, the final product of that bargaining was a contract which realized many, if not most of the goals I described in my testimony as needed reforms in the health care delivery system and which were incorporated into the Guidelines published by the Insurance Department. (See, Exhibit 15). For example, at pages 45-48 of the transcript, I urged greater control over medical education costs. (Guideline No. 3) In response, Section 1.4 of Exhibit A to the 1971 Agreement imposes certain limitations on these costs for purposes of Blue Cross reimbursement. At pages 43-45 and 52-54 of the transcript, I argued for licensing legislation which would require approval of new capital projects and expansions of services, as well as recertification of existing services and facilities. (Guidelines 1 and 2) Section 24 of the 1971 Agreement achieves essentially the same result through employment of an independent private planning agency, the Hospital Survey Committee ("HSC"), which reviews any request for expansion, while periodically reviewing all existing facilties to ensure they conform with current safety standards and such are indeed necessary. In the event HSC makes an adverse findng as to either the need for a new or existing service or facility, the 1971 Agreement provides no depreciation or interest expense with respect to such will be reimbursed by the Plan. Similarly, my comments with regard to staffing patterns, page 48-50 (Guideline 4), depreciation, pages 50-52 (Guideline 5 and 35) and length of stay, page 56 (Guidelines 18, 19, 23 and

34) have found expression in the 1971 Agreement as well as a substantial majority of the items identified in the Insurance Department's Guidelines.

81. The indirect form of regulation achievable through contractual arrangements which are reviewable by a state agency, but not capable of direct imposition may be blunted by a breakdown in negotiations between the private contracting parties. In such cases the stimulus of compulsory mediation, such as that required by Act No. 94, is often helpful. Clearly this was the solution selected by the Pennsylvania General Assembly when it passed House Bill 1347.

82. Prior to signing this bill into law, Governor Shapp personally acquainted himself fully with the negotiations between the Plan and the DVHC represented hospitals. Paragraph 5 of the Guest Affidavit describes his involvement and unequivocally admits that the Governor signed Act No. 94 only after it was clear to him that no immediate resolution to the negotiating impasse was near and action was required to protect the public interest.

83. The Williamson Affidavit suffers from many of the same infirmities which characterized the Guest Affidavit and are fully answered in the accompanying affidavit of Mr. Lynch, the Plan's Executive Vice-President. However, I would note that Mr. Williamson makes an interesting admission in his Affidavit when he concedes the Plan pays the full cost of the covered medical services rendered its Subscribers, but argues this is not enough for the Plan should also subsidize hospitals for those patients from whom it is unable to collect costs. Clearly, the DVHC admits that Act No. 94, by requiring the reinstatement of the 1971 Agreement, will not force a hospital to lose money on the Blue Cross portion of its business, but only prevent it from realizing a "profit".

84. Although the Williamson Affidavit repeatedly refers to free care losses it does not indicate that many of the DVHC represented hospitals have received substantial funds under what is commonly referred to as the Hill Burton Act. (42 USC § 291 *et seq.*) These sums are given as either outright grants or low cost loans by the Federal government to assist in hospital construction. As the *quid pro quo* for these taxpayer dollars, the hospital is required to provide "a reasonable volume of services to persons unable to pay therefor. . . ." (42 USC § 291c(e)(2)) In a recent decision involving this statute it was held "a recipient of Hill Burton funds is required by the statute to provide such services in such portion or portions of its facility as will constitute a reasonable volume in light of the needs of the community and the amount of the grant." *Corum* v. *Beth Israel Medical Center*, 359 F. Supp. 909, 917 (S.D.N.Y. 1973). Moreover, a recent HEW regulation (42 CFR § 53.111) requires that a hospital recipient of Hill Burton funds must regularly advertise this fact and solicit patients who are financially or medically indigent. A copy of this regulation and the accompanying discussion of this ruling which appeared in the Federal Register is attached as Exhibit 45. Clearly, having elected to utilize federal funds, it is difficult to understand why the hospital should now seek to collect from others the cost of rendering the free care which it is required by law to provide.

85. The two hospitals identified in the Affidavits of Clark ("Episcopal") and Anderson (Mercy Catholic Medical Center—"MCMC") were beneficiaries of Hill Burton funds. Episcopal received $1,581,200 in May 1964, and later in February 1971, an additional $400,000. MCMC was given $866,000 in May 1974 with an additional $954,000 provided as a 3% loan. Importantly it should be recognized that although these funds were provided from tax rev-

enues, the Plan reimburses these hospitals for the full "depreciation" attributable to the facilities built with these monies without any setoff for the government's contribution.

86. Although I am obviously not intimately familiar with the source of all major hospital capital contributions, the fact that the main building at Fitzgerald Mercy-MCMC was a gift is well chronicled. However, as with hospitals built utilizing government funds, the Plan, pursuant to the 1971 Agreement, allows full "depreciation" on the contributed structure notwithstanding the fact that such contributions are subsidized by the general public in the form of lost tax revenue.

87. Although the Guest and Williamson Affidavits argue that hospitals have substantial free care losses, I am not aware of any statute or regulation, other than the Hill Burton Act, which requires a hospital provide patient care without compensation. Indeed, both the Medicare and Medicaid programs are voluntary and a hospital may elect not to participate. Thus, if a hospital does in fact provide care for which it not fully paid, it must be in recognition of its charitable character and as a recognition of the substantial tax deductible contributions that it does receive.

88. Paragraph 8 of the Williamson Affidavit makes an interesting concession when he suggests "unrestricted endowment fund income can be applied to reduce the hospitals net operating loss". However, he asserts Episcopal, MCMC and Presbyterian are in such dire financial condition as to preclude this action, although a review of their financial statements accompanying the Clark, Anderson and Mosher Affidavits shows each hospital's assets increased during the reporting period. Further Mr. Lynch's Affidavit underscores certain questionable expenses which purportedly produced a net operating loss.

89. None of the affidavits filed on behalf of the Plaintiffs in this case specifically identify the source of their unreimbursed patient care losses. Rather, they point vaguely to free care services, bad debts and the like. For my part, I believe a goodly position of these purported "losses" may be traced to the effect of the 1971 Agreement in requiring all hospitals implement effective cost and quality control measures. As indicated in paragraph 80 above, depreciation and interest on capital projects and facilities which do not meet safety or need standards are no longer reimbursed. The costs attendant hospitalization, whether in whole or part, that is not medically appropriate will similarly not be reimbursed. (See Principle II, 1973 Agreement) Further, generic rather than brand name drugs are required except in isolated cases (Section 16), purchasing proceures must conform with the prudent buyer concept (Section 19), and strict budget controls must be followed (Section 18). In cases where these rules are not followed reimbursement is reduced or denied. When added to the losses hospitals incur in areas not involving the rendition of patient care, there seems little to substantiate any allegation of true losses attributable to patient care.

/s/ BRUCE TAYLOR

Bruce Taylor

Sworn to and subscribed
before me this day
of November, 1975.

Notary Public
My Commission Expires

AFFIDAVIT OF JEROME LYNCH
EXECUTIVE VICE PRESIDENT,
BLUE CROSS OF GREATER PHILADELPHIA

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } *ss:*

JEROME LYNCH, being duly sworn according to law, deposes and says that he is the Executive Vice-President of Blue Cross of Greater Philadelphia, one of the defendants named in the foregoing action; that as such he is duly authorized to, and does make this Affidavit on its behalf based on his personal knowledge, and that such statements are true and correct. Further, deponent says in reply to the Affidavits of Paul I. Guest, Chairman of the Delaware Valley Hospital Council and President of Methodist Hospital ("Guest Affidavit"), Joseph A. Williamson, President of the Delaware Valley Hospital Council ("Williamson Affidavit"), Fred G. Clark, Vice-President of Finance, Episcopal Hospital ("Clark Affidavit"), Ragnar W. Anderson, Acting Director of Fiscal Affairs and Controller of Mercy Catholic Medical Center ("MCMC"), Fitzgerald Mercy Division ("Anderson Affidavit"), and Carl L. Mosher, President of Presbyterian-University of Pennsylvania Medical Center ("Presbyterian") ("Mosher Affidavit"), that:

1. Paragraph 14 of the Guest Affidavit suggests that Jeanes Hospital will lose more than $50,000 in the current year. Yet, the most current financial statement of that hospital which was included as Exhibit 36 to the Taylor Affidavit indicates it earned $303,650 in 1973 and $284,945 in 1974. Further, if "depreciation", which amounted to more than a quarter of a millon dollars in each of these

years and is largely attributable to contributed property be added to this net, Jeanes Hospital has realized an annual profit of more than half a million dollars. In light of these facts, it is difficult to understand how the Hospital can now allege it will lose more than $50,000 in the current year.

2. The closing "argument" contained in the Guest Affidavit suggests that Jeanes Hospital is unique in having a "financially secure" position. This is unsupported by an analysis of the most recent financial statements of the other DVHC represented hospitals. For example, Taylor Hospital realized an operating profit each year from 1971 to 1975. When non-operating revenues are added, the net profit for that Hospital in 1974 was $750,066 and $291,719 in 1975. Interestingly, Taylor Hospital showed an increase of over $1.2 million in its unrestricted fund balance from 1974 to 1975, hardly the sign of a financially ill institution. A copy of the financial statement of Taylor Hospital, as of June 30, 1975, prepared by its certified public accountants, Maillie, McCarraher, Lennon & Co. is attached hereto as Exhibit A.

3. Lest it be thought Taylor Hospital is an isolated example of a DVHC represented hospital which has had a favorable operating experience, there are attached hereto copies of the most recently available operating statements of Sacred Heart Hospital-Norristown (Exhibit B), Doylestown Hospital (Exhibit C), Sacred Heart General Hospital (Exhibit D), Riddle Memorial Hospital (Exhibit E), Wills Eye Hospital (Exhibit F), Paoli Memorial Hospital (Exhibit G), and Delaware County Memorial Hospital (Exhibit H), all of which hospitals realized operating profits for the past two years. Of course, these hospitals also realized significant non-operating income which added significantly to their earnings per-

mitting large increases in net worth. Indeed, if all the financial statements of the DVHC represented hospitals were to be inspected, most, if not all would show yearly profits, even after allowance for "depreciation" and losses not connected with patient care.

4. Obviously, Mr. Williamson failed to consult the hospitals referred to above prior to the preparation of his Affidavit since he alleges in paragraph 5 that all hospitals suffer operating losses. Further, he ignores the fact that most of the DVHC represented hospitals, including two of three carefully selected ones referred to in his Affidavit, received significant Hill Burton funds for the construction of their facilities. As Mr. Taylor indicated in his Affidavit, the statutory and case law requires that hospitals taking such funds must provide certain amounts of free care.

5. Paragraph 4 of the Williamson Affidavit indicates that a "substantial portion" of a hospital's bad debt cost is attributable to treating inpatients who enter the hospital as Blue Cross Subscribers but whose coverage expires prior to their discharge. Since this allegation is not supported by any substantive evidence to the best of my knowledge it would be well to review the clearance procedure employed by the Plan. When a Subscriber is admitted, the hospital, by phone or telex, inquires of the Plan as to whether or not the individual is entitled to Blue Cross benefits. In its response, the Plan advises of the status of the individual and further, indicates the number of covered inpatient days to which he is entitled. Thereby, the hospital is placed on notice as to the amount of coverage for which the Plan is liable and may, at the expiration of the covered period charge the Subscriber the full retail rate or charges for any continuing stay. Thus, although there may be some bad debts incurred, such are properly

attributable to the hospital's poor administrative or collection procedures.

6. The Clark, Anderson and Mosher Affidavits contain various allegations as to the perilous financial conditions of the three identified hospitals and their relationship with the Plan. Although I will not respond to each and every allegation, certain factual inaccuracies or omissions are of sufficient significance to mandate a reply.

7. The Clark Affidavit suggests in paragraph 5 that Episcopal Hospital had a net operating loss for the fiscal year ended June 30, 1975 of $1,296,301. In support of this position, Mr. Clark attaches the financial statement prepared by its auditors, Coopers & Lybrand. However, what the Clark Affidavit does not say is that this loss is not a true operating loss for it reflects many expenses not associated directly with the hospital operation.

8. Included in the operating expenses incurred by Episcopal, shown on page 4 of its statement, are certain costs not attributable to patient care rendered at the Hospital. For example, based on costs reports submitted to the Plan, Episcopal expended during fiscal 1975 a total of $961,124 on its outpatient clinic, a supposedly government financed Model Cities program, $597,726 on emergency room services, $473,397 on the Harrison House, a retirement home, $844,933 for off-site mental health facilities, another government sponsored program, $156,000 on off-site rental units, and $31,586 for its coffee, thrift and gift shops. However, the revenues realized from governmental sources for the outpatient clinic and mental health facility amounted to no more than the $929,632 shown on the operating statement as the total governmental supplement to the Hospital, thereby creating a loss of at least $900,000. Further, the Harrison House, a home for Episcopalian retirees, produced a loss of $189,000 when costs

are netted against revenues as shown by the Hospital's own trial balances. Similar losses of somewhat smaller proportions also resulted from the other areas identified above and when aggregated exceed the claimed net operating loss. Further, if realized non-operating revenues of $661,000 be added, the institution showed a healthy profit for fiscal 1975.

9. Paragraph 7 of the Clark Affidavit suggests Episcopal was required to reduce its endowment fund principal by nearly $1 million during the period 1973-1975, but its financial statements for those periods indicate both its restricted and unrestricted funds increased as below:

Year	Restricted Funds	Unrestricted Funds
1973	$6,511,362	$7,919,956
1974	6,653,887	7,837,551
1975	6,700,800	8,044,753
TOTAL INCREASE—$324,235		

Further, an actual inspection of these financial statements show that at year end 1973 the endowment fund was costed at $6,060,004, while at the same date in 1975 it was $6,062,936. Importantly, this fund is carried per books at cost, while the balance sheet shows that the market value at June 30, 1975 of this fund was $8,346,330.

10. Although paragraphs 10, 11 and 12 of the Clark Affidavit suggest Episcopal has been forced to invade endowment fund principal to meet current operating expenses such is not fact. Whether money for operations be derived from "depreciation" or other sources is largely academic. The Hospital did indeed show gains in its restricted and unrestricted funds during the referenced periods and any operating loss is traceable to non-hospital related functions.

11. The Auditors' Report prepared by MCMC's certified public accountants, Haskins & Sells, upon which the Anderson Affidavit is based requires two observations. First, the Report is prefaced by a "qualified" opinion and, secondly, the Report is dated August 14, 1975 although it purports to cover a period fourteen months prior. Since it is the normal practice of accounting firms to submit audited statements within 90 days after the close of the period, this delay would suggest that the books and records of MCMC were either incomplete or required revision at the end of the indicated fiscal period.

12. The certified public accountants retained by the Plan to prepare the final audits required by the 1971 Agreement also had considerable difficulty in obtaining access to MCMC's books of account, invoices and other financial documents, as is shown by letters and status reports from Ernst & Ernst, copies of which are included as Exhibit I. A check of the status of all other hospital field audits conducted for the Plan indicates that MCMC is the only one still outstanding as of this writing.

13. Note 2 to the MCMC statement is also somewhat disturbing, since the Hospital has been required to write-off substantial accounts receivable which suggests some weakness in the financial accounting procedures of that institution as is well evidenced by the auditor's "qualified" opinion.

14. In paragraph 5 of the Anderson Affidavit, he indicates MCMC made provision for free care and uncollectible accounts amounting to $3,043,544. This figure, computed at charges which would necessarily include the hospital's markup, must incorporate some provision for write-offs of accounts receivable for prior years which were theretofor included as assets. Due to this treatment it cannot be said with any degree of certainty what the

true operating results of MCMC were for the indicated fiscal period.

15. The mark-up of charges over Blue Cross cost which is alleged in paragraph 7 of the Anderson Affidavit is difficult to confirm, although the Plan's calculation indicates the figure to be substantially less.

16. The allegation in paragraph 8 that MCMC experienced delay in the receipt of Blue Cross reimbursement averaging 42 days is most distressing. A special study of current billings conducted specifically to assess the correctness of this charge indicates the Plan remits, to all contracting hospitals, 96% of its billings within 14 days and 99% within 30 days of receipt. Interestingly, an analysis of MCMC's recent billings reveals several internal problems at that Hospital. The average time from the date a patient is discharged from MCMC to the billing date shown on its invoices submitted to the Plan averaged more than 14 days. Moreover, a 10-day delay was noted between the invoice date and the actual date the invoice was mailed. For its part, the Plan's turnaround time between receipt of invoices and disbursement of payment, exclusive of weekends, was approximately 5 days. Importantly, in order to develop the foregoing averages it was necessary to completely eliminate many invoices applicable to hospitalizations in early 1975 when the in-hospital delay incurred in preparing billings ran upwards of six months after the date of the patient's discharge.

17. Exhibit A to the 1973 Agreement contemplated that hospitals would complete and submit billings within 7 days after discharge and the Plan would process such within 6 days after receipt, plus an allowance of two days for mail deliveries to produce an anticipated delay of 15 days. The advance program referred to in paragraph 8

of the Anderson Affidavit, which is fully described in Exhibit A to the 1973 Agreement, was intended to provide working capital to cover this period. However, in cases where the delay is clearly due to administrative delays within the hospital the advance program cannot be faulted.

18. The Mosher Affidavit is based on the financial reports prepared by its certified public accountants, Coopers & Lybrand for the period ended June 30, 1974. Since the Plan had received the certified financial statement of Presbyterian under date of September 12, 1975 from Coopers & Lybrand for the fiscal period ended June 30, 1975, I would be at a loss to explain why the stale financial statement was used were it not for the fact that Presbyterian showed a remarkable turn-around in fiscal year 1975 which apparently Mr. Mosher feels would detract from his presentation. A copy of the 1975 statement is attached as Exhibit J.

19. In paragraph 5 of the Mosher Affidavit, it is alleged that Presbyterian provided free care amounting to an "unrecovered cost to the Hospital of $847,500". However, as this figure is based on charges that have been written off and therefore constitutes uncollected revenue, it is not a true bare bones cost, but rather includes a mark-up to retail. Therefore, the free care loss, if indeed it could be called that, is substantially less than the figure indicated.

20. Although Mr. Mosher indicates in paragraph 7 that Presbyterian showed a "bottom line net loss of $789,000 for fiscal 1974", this includes expenses attributable to nonreimbursable areas, such as research and a convalescent home maintained by the Hospital. Further, the loss is inflated by a charge of $184,933 arising from fund

raising functions which undoubtedly added "restricted" funds which have not been included in the income statement. The fact that these non-patient care related costs are substantial and the Hospital itself has not been financially injured, is well demonstrated by the fact that Presbyterian realized a year-to-year increase in all its fund balances, both restricted and unrestricted, for the instant reporting period over that of the prior year.

21. Mr. Mosher states in Paragraph 9(a) that the Plan improperly withheld certain reimbursement which was properly due and payable. This certainly is not the case. During 1970, the Plan challenged the costs of Presbyterian as being out-of-line with those of comparable hospitals in accordance with Principle 2-1 to Exhibit A of the 1967 Agreement. The final settlement of $330,000 represented a compromise achieved through negotiations between the Plan and Hospital which tacitly recognized the validity of the Plan's position. Further, Section 15 of the 1967 Agreement specifically provided for appeals through an arbitration and ultimately the courts in the event the contracting parties were unable to amicably resolve their differences. The fact that Presbyterian failed to pursue this remedy is not to be overlooked.

22. Paragraph 9(b) of the Mosher Affidavit suggests that the Plan has been delinquent in not settling its account with Presbyterian for the fiscal year ended June 30, 1975. This is not so. The Hospital's cost report was received by the Plan on September 24, 1975. Thereafter, on October 8, 1975, Presbyterian notified the Plan of a material error in its report and on October 17, 1975 the revised schedule correcting the errors in the original report was received. A copy of the Memorandum and letter from John Kohler, Presbyterian's Cost Manager advising of these discrepancies is attached as Exhibit K hereto.

23. Mr. Mosher alleges in Paragraph 9(c) of his affidavit that the Plan has failed to revise and adjust Presbyterian's interim per diem reimbursement rates in accordance with the Hospital's fiscal 1976 operating budget. What he fails to add is that the budget of September 10, 1975, required additional information, and such was submitted by letter dated October 6, 1975, a copy of which is attached as Exhibit L. Since Section 18 of the 1971 Hospital Agreement affords the Plan a 45 day period in which to review operating budgets and adjust interim rates, the time frame within which such action should take place has not yet expired. However, if the Plan fails to act within this period, Section 18 further provides the hospital's budgeted rate will then become effective.

/s/ JEROME LYNCH
Jerome Lynch

(Oath and Jurat Omitted in Printing)

Opinion and Order of February 27, 1976 (appended to Jurisdictional Statement)

Supreme Court, U. S.
FILED
NOV 22 1976
MICHAEL RODAK, JR., CLERK

EXHIBITS TO APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1691

Paul I. Guest, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

No. 75-1698

Williamsport Hospital, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

Appeals from the United States District Court for the Eastern District of Pennsylvania

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No. 75-1691, Filed May 21, 1976
No. 75-1698, Filed May 24, 1976
Probable Jurisdiction Noted October 4, 1976

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H.	Financial Statement of Delaware County Memorial Hospital as at June 30, 1974	(omitted)
I.	Correspondence and Memorandum re Mercy Catholic Medical Center Medicare Cost Audit	(omitted)
J.	Financial Statement of Presbyterian-University of Pennsylvania Medical Center as at June 30, 1975	(omitted)
K.	Memorandum and Letter from Cost Manager of Presbyterian-University of Pennsylvania Medical Center	(omitted)
L.	Letter from Controller of Presbyterian-University of Pennsylvania Medical Center	(omitted)

Exhibit A

A. EXHIBITS TO AFFIDAVITS OF APPELLANTS

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } *ss:*

FRED G. CLARK, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the Vice President of Finance of Epsicopal Hospital, a non-profit corporation organized under the laws of Pennsylvania and located at Front Street and Lehigh Avenue, Philadelphia, Pennsylvania 19125.

2. That in this capacity, and previously as Comptroller, he is responsible for maintaining the fiscal viability of Episcopal Hospital and has responsibility for recommending to the President for transmittal to the Board of Trustees a schedule of patient charges in accordance with this purpose; he has discharged these duties for two and a half years.

3. That he has read the Affidavit of Edward J. Armstrong in support of the Motion for Summary Judgment by Plaintiffs and Plaintiffs Intervenors and agrees with and incorporates herein the facts stated in that Affidavit insofar as they describe the general principles of sound fiscal policy which a hospital must adhere to and the manner in which the provisions of the Delaware Valley Agreement affect fiscal policy.

4. That specifically Blue Cross refuses to recognize in its reimbursement under the Delaware Valley Agreement the Hospital's expense in providing free care and in covering losses due to bad debts other than those of Blue Cross subscribers; that the Blue Cross reimburse-

Exhibit A

ment formula does not permit a hospital to meet its current operating needs; and further, that the reimbursement formula fails to make adequate provision for the expansion, replacement or improvement of the Hospital's plant and equipment in the form of an "operating growth needs factor" as detailed in paragraphs 11-14 of Mr. Armstrong's Affidavit.

5. That Episcopal Hospital's financial statement for the fiscal year ending June 30, 1975, prepared by Coopers and Lybrand, shows an operating loss of $1,296,301. (This financial statement is attached hereto at Attachment "A".)

6. That in fiscal year 1975 Episcopal's net unreimbursed charges for patient care amounted to $1,480,402 which includes $583,582 for free care, $1,067,105 for bad debts, less $170,285 in payments from the City of Philadelphia towards outpatient and emergency room services.

7. That the amount of unreimbursed patient care which ought to be reimbursed by Blue Cross in proportion to the percentage of inpatient charges for services rendered Blue Cross subscribers (22.78%), but which Blue Cross will not reimburse under the Delaware Valley Agreement, is $337,235.

8. That it would be plainly impossible for the 11.37% of Episcopal Hospital's paying patients who are either self-insured or insured by private insurance companies to pay increased charges sufficient to absorb losses suffered by the Hospital as a result of unreimbursed patient care.

9. That in order to offset the operating loss of $1,296,301 for fiscal year 1975, Episcopal Hospital applied the full amount of interest earned by its endowment fund or $474,721 plus additional non-operating income from other sources to produce a net loss for that year of $635,217. The corresponding net loss figure for fiscal year 1974 was $573,811 and for fiscal year 1973, $646,388.

Exhibit A

10. That under Pennsylvania law (Section 7550 of the Pennsylvania Non-profit Corporation Law of 1972, 15 Pa. C.S. § 7550), a non-profit corporation may transfer from the accumulated net gains of its endowment funds an amount up to a maximum of nine (9%) per cent per year of market value less income received. Episcopal Hospital took full advantage of this provision in fiscal year 1975 to transfer $231,050 from its endowment principal. In fiscal year 1974, it transferred $437,375, and the Board of the Hospital has voted to transfer $273,792 in fiscal year 1976 to meet the Hospital's operating expenses. Thus, in three years, Episcopal Hospital will have been required to reduce its endowment fund principal by close to $1,000,000.

11. That for fiscal year 1975 the depreciation reserve for Episcopal Hospital was $633,298. In order to show a break-even figure for that year, it would be necessary to apply $404,167 or nearly two-thirds of the depreciation fund towards the net loss figure of $635,217 as reduced by the $231,050 taken from endowment fund principal. Alternatively, Episcopal could have avoided cutting into its endowment principal and instead applied virtually all of its depreciation funding to offset its net losses for fiscal year 1975.

12. That in order to meet its normal operating expense, Episcopal Hospital has been forced for the past two years to apply its total endowment fund income, to reduce its endowment fund principal to the extent permitted by law, and to deplete its depreciation reserve by nearly two-thirds to offset a net operating loss, a pro rata share of which ought to be reimbursed by Blue Cross subscribers in common with all other paying patients, but is not recoverable from Blue Cross under the principles of reimbursement in the Delaware Valley Agreement.

Exhibit A

The foregoing is true and correct to the best of my personal knowledge.

/s/Fred G. Clark

Fred G. Clark

(Oath and Jurat Omitted in Printing)

Exhibit B

Commonwealth of Pennsylvania }
County of Philadelphia } *ss:*

Ragnar W. Anderson, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the Acting Director of Fiscal Affairs and Controller of Mercy Catholic Medical Center, Fitzgerald Mercy Division ("MCMC"), a non-profit corporation organized under the laws of Pennsylvania and located at Lansdowne Avenue and Baily Road, Darby, Pennsylvania, 19023.

2. That he is responsible for maintaining the fiscal viability of MCMC and has authority for recommending to management and the Board of Trustees a schedule of patient charges in accordance with this purpose; he has discharged these duties at MCMC for three years.

3. That he has read the Affidavit of Edward J. Armstrong in support of the Motion for Summary Judgment by Plaintiffs and Plaintiffs Intervenors and agrees with and incorporates herein the facts stated in that Affidavit insofar as they describe the general principles of sound fiscal policy which a hospital must adhere to and the manner in which the provisions of the Delaware Valley Agreement affect fiscal policy.

4. That specifically Blue Cross refuses to recognize in its reimbursement under the Delaware Valley Agreement the Hospital's expense in providing free care and in covering losses due to bad debts other than those of Blue Cross subscribers; that the Blue Cross reimbursement formula does not permit a hospital to meet its current operating needs, and further, that the reimburse-

ment formula fails to make adequate provision for the expansion, replacement or improvement of the Hospital's plant and equipment in the form of an "operating growth needs factor" as detailed in paragraphs 11-14 of Mr. Armstrong's Affidavit.

5. That for fiscal year 1974, the total cost to MCMC of unreimbursed patient care including free care and bad debts was $3,043,544, as shown on the Hospital's certified financial statement attached hereto at Attachment "A."

6. That if Blue Cross paid MCMC their share of these costs in the same proportion which Blue Cross covered charges bear to total charges entered by the Hospital against its patients, Blue Cross would have paid MCMC an additional $655,624 (represented by $851,938 in charges), for fiscal year 1974. Blue Cross would pay no part of these costs under the Delaware Valley Agreement.

7. That in order partially to reduce its losses resulting from unreimbursed patient care, MCMC is required to surcharge its private paying patients. Thus, whereas Blue Cross reimbursement for an eight-day hospital stay during fiscal year 1974 would have been $856, commercial insurance companies paid MCMC an average of $1,238, or 44% more than the amount payable by Blue Cross. Among other commercial insurers which reimburse MCMC full charges without even a patient co-payment requirement are Aetna, Prudential and Metropolitan.

8. That, in addition to the fact that Blue Cross does not reimburse MCMC full charges under the Delaware Valley Agreement, even such payments as it does make are not available for current operating expenses. This is because the contract provision for working capital advances presupposes a 15-day cycle from the time of billing to the time of payment while, in fact, the experience at MCMC has been that this delay in payment averages

42 days. Thus, at any given time, MCMC has about half a million dollars more in unreimbursed costs due from Blue Cross than contemplated by the 15-day working capital advance program.

9. That both on a short and long-term basis, MCMC is forced to use virtually all of the money that would otherwise have been funded from depreciation in order to meet its operating expenses and accordingly, is required to borrow money for capital improvements.

10. That MCMC has virtually no endowment fund income from which to make up operating costs not reimbursed by third party payors like Blue Cross.

The foregoing is true and correct to the best of my personal knowledge.

/s/ RAGNAR W. ANDERSON

Ragnar W. Anderson

(Oath and Jurat Omitted in Printing)

Exhibit C

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } *ss:*

CARL L. MOSHER, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the President of Presbyterian-University of Pennsylvania Medical Center ("PUPMC"), a non-profit corporation organized under the laws of Pennsylvania and located at 51 North 39th Street, Philadelphia, Pennsylvania 19104.

2. That he is responsible for maintaining the fiscal viability of PUPMC and has final authority for recommending to the Board of Trustees a schedule of patient charges in accordance with this purpose.

3. That he has read the Affidavit of Edward J. Armstrong in support of the Motion for Summary Judgment by Plaintiffs and Plaintiffs Intervenors and while he is not familiar with matters relating specifically to Jeanes Hospital, agrees with and incorporates herein the general principles stated in that Affidavit insofar as they describe the general basis of sound fiscal policy which hospitals must adhere to and the manner in which the provisions of the Delaware Valley Agreement affect fiscal policy.

4. That specifically Blue Cross refuses to recognize in its reimbursement under the Delaware Valley Agreement the Hospital's expense in providing free care and in covering losses due to bad debts other than those of Blue Cross subscribers; that the Blue Cross reimbursement formula does not permit a hospital to meet its full current operating needs; and further, that the reimbursement formula fails to make adequate provision for the

Exhibit C

expansion, replacement or improvement of the Hospital's plant and equipment in the form of an "operating growth needs factor" as illustrated in the example detailed in paragraphs 11-14 of Mr. Armstrong's Affidavit.

5. That for the fiscal year 1974, PUPMC provided free care, exclusive of bad debts, amounting to an unrecovered cost to the Hospital of $847,500.00, or 5% of the Hospital's total reimbursable costs.

6. That, since Blue Cross patients represent approximately 24% of total patient billings, and following standard Medicare principles of reimbursement in allocating costs on the basis of charges, the pro rata share of the unrecovered cost of free care which ought to have been paid by Blue Cross in fiscal year 1974 was at least $203,400. Under the principles of reimbursement in the Delaware Valley Agreement, Blue Cross refuses to pay any portion of this amount.

7. That as a result in large part of losses due to unreimbursed patient care (paragraph 6), PUPMC showed an operating loss for fiscal year 1974 of $1,774,000, per Coopers and Lybrand Certified Audit Reporting. After applying against this operating loss $985,000 of income from unrestricted contributions, PUPMC showed a bottom line net loss of $789,000 for fiscal year 1974. (A copy of the certified financial statement for PUPMC for fiscal year 1974 is attached hereto at Attachment "A".)

8. That not only does Blue Cross pay PUPMC less than its pro rata share of the Hospital's total cost of operation, but frequently what it has paid, has been paid only after considerable delay and, at no time, has PUPMC been paid interest for the period of time when money already earned by PUPMC continued to earn interest for Blue Cross.

Exhibit C

9. That the following examples of delay suffered by PUPMC in receiving payments from Blue Cross put in perspective the latter's provision of an advance equal to 15 days of current costs and offer of an additional 15-day advance upon which, if utilized, the Hospital must pay interest (see Supplemental Affidavit of Bruce Taylor at paragraphs 70-71):

(a) During 1970 and 1971, Blue Cross challenged PUPMC allowable costs and refused to pay any part of the challenged costs of $541,911 for the fiscal year ending June 30, 1970, until on January 3, 1973, the Hospital settled for $330,000 or 61 per cent of the disputed costs which it had expended more than two years earlier. It was only after the Hospital had agreed to settle for less than cost reimbursement that the Hospital also received payment of $478,247 held back for the fiscal year 1971. Thus, Blue Cross held back almost $1,000,000, some of this for more than two years. The Hospital never received any interest on that money.

(b) On September 22, 1975, the Hospital filed with Blue Cross its Blue Cross cost report for the fiscal year ended June 30, 1975. That cost report reflects a substantial sum of unreimbursed money owing to the Hospital for the prior fiscal year. As of the date of this writing, the Hospital has received no response from Blue Cross. It is the Hospital's understanding that its fiscal 1975 cost report was one of the first four or five cost reports received by Blue Cross.

(c) Subsequent to the enactment of Act 94 and pursuant to the understanding that the parties would proceed in accordance with the provisions of that Act, the Hospital responded to a request by Blue Cross and on September 10, 1975, submitted its operating

Exhibit C

budget for fiscal year 1976. The main purpose of this budget submission was to provide Blue Cross with financial data to revise and adjust interim per diem reimbursement rates. As of the date of this writing, the Hospital has received no increase in interim per diem rate from Blue Cross.

10. That, at least in part as a result of the inadequacy of Blue Cross reimbursement and the delay in receipt of Blue Cross payments, PUPMC has insufficient working capital requiring the Hospital, in many cases, to borrow money at high interest rates simply to meet its operating expenses.

The foregoing is true and correct to the best of my personal knowledge.

/s/ CARL L. MOSHER

Carl L. Mosher

(Oath and Jurat Omitted in Printing)

Exhibit 1

B. EXHIBITS TO AFFADAVITS OF APPELLEES

AMENDED AND RESTATED
ARTICLES OF INCORPORATION
OF
BLUE CROSS OF GREATER PHILADELPHIA

ARTICLE I. The name of the corporation is:

BLUE CROSS OF GREATER PHILADELPHIA

ARTICLE II. The address of its registered office in this Commonwealth is:

1333 Chestnut Street
Philadelphia, Pennsylvania 19107

ARTICLE III. The corporation does not contemplate pecuniary gain or profit, incidental or otherwise. The purposes for which it is formed are:

1. To establish, maintain and operate a non-profit plan whereby hospitalization and health benefits may be provided to subscribers to such plan.

2. To make and enter into contracts with duly licensed hospitals, extended care facilities, nursing homes, convalescent homes and other organizations to provide any of the services to subscribers to such plan for which benefits or coverages are contemplated pursuant to paragraph 3 hereof.

3. To establish a plan providing (a) certain hospital services to be rendered by such hospitals to subscribers, (b) indemnities for certain medical services only when incident to hospitalization in duly licensed hospitals, to wit: laboratory, electro-cardiographic and x-ray examinations, metabolism tests, anesthesia and physical therapy, to be

Exhibit 1

rendered by physicians to subcribers in accordance with the arrangements then existing between the hospitals and the physicians rendering such services, and (c) any or all of the following benefits or coverages, except that the corporation shall not pay for any doctors' professional services to patients in connection with any of the following benefits or coverages:

(1) extended benefits or major medical coverage indemnifying subscribers for certain expenses in excess of the benefits included in the basic coverage,

(2) benefits in extended care facilities and nursing or convalescent homes,

(3) nursing care, including visiting nurse service,

(4) home care, consisting of an organized program of health services provided under the direction of a physician to a patient at home,

(5) drugs, medicines and medical supplies and appliances for use outside of a hospital,

(6) any and all other health or related services, including without being limited to, hearing and vision care, and multiphasic screenings.

4. To issue subscription agreements to subscribers to the said non-profit plan and to enter into group contracts in accordance with these purposes.

5. To act as an agency or organization under Section 1816 of Title XVIII of the Federal Social Security Act, known as "Medicare," 42 U.S.C.A. Section 1395h, and its amendments, with power to perform all the services which may be required of an agency or organization thereunder; to perform services, similar or related to those which may be required of an agency or organization as aforesaid, in connection with any federal, state or local governmental

health care program; to perform services, similar or related to those which may be required of an agency or organization as aforesaid in connection with or associated with non-governmental organizations, individuals, groups and agencies in the health care field.

6. To do everything and anything necessary, suitable, proper, convenient and incidental to the aforesaid purposes, or which may be done by a corporation organized for such purposes under the laws of the Commonwealth of Pennsylvania, together with all the powers now or which may hereafter be permitted to it by the laws of the Commonwealth of Pennsylvania.

ARTICLE IV. The corporation shall exist perpetually.

ARTICLE V. The corporation is organized on a non-stock basis.

ARTICLE VI. The corporation shall have no members.

ARTICLE VII. (a) The business and affairs of the corporation shall be managed by a board of at least 25 directors. All of the directors of the corporation (except not to exceed five ex-officio directors selected as may be provided in the by-laws and except directors selected for such terms as may be provided in the by-laws to fill vacancies) shall be elected by the Subscribers to the non-profit plan established, maintained and operated by the corporation (herein referred to as the "Subscribers") or their proxies in such manner and for such terms as may be provided in the by-laws. All directors of the corporation shall be Subscribers residing within the area served by the corporation. The by-laws may provide fair and reasonable procedures for the nomination of candidates for the office of director, but such by-laws shall always

permit 300 or more Subscribers to place any eligible person in nomination for the office of director in the manner provided in such by-laws.

(b) At any special meeting of the Subscribers called for the purpose in the manner prescribed in the by-laws by 10% of the Subscribers entitled to vote at an election of directors, the entire board of directors, or any individual director may be removed from office without assigning any cause, by a majority vote of Subscribers present in person or by proxy and voting at such meeting. In case the Board or any one or more directors is so removed, new directors may be elected at the same meeting.

ARTICLE VIII. (a) Any of the following plans or other corporate action may be proposed by petition of 10% of the Subscribers entitled to vote at an election of directors, which petition shall be directed to the board of directors and filed with the Secretary of the corporation:

(1) The amendment of the articles or the adoption, amendment and repeal of the by-laws.

(2) A plan of sale, lease or exchange of assets under 15 Pa. S. § 7930.

(3) A plan of merger, consolidation, division or conversion.

(4) The voluntary dissolution of the corporation.

(b) Except as provided in Paragraph (c) of this Article, any plan or other corporate action specified in Paragraph (a) of this Article, after having been proposed either by the board of directors or by petition of Subscribers, shall be submitted to a meeting of Subscribers (to be held not more than 60 days after the receipt of a petition, in the case of a meeting of Subscribers to consider and take action on any matter pro-

posed by petition under Paragraph (a) of this Article), and shall be deemed adopted by the corporation when, and only when, approved by the affirmative vote of a majority of Subscribers present in person or by proxy and voting at any regular or special meeting of Subscribers called and held as may be provided in the by-laws, and approved in writing by the Insurance Commissioner and the Governor of the Commonwealth of Pennsylvania.

(c) Unless otherwise restricted in a by-law adopted by the Subscribers after September 1, 1973, the board of directors shall have the full authority vested by law in the board of directors of a corporation without members to adopt, amend and repeal the by-laws of the corporation.

BY-LAWS
OF
BLUE CROSS OF GREATER PHILADELPHIA

ARTICLE I

Subscribers

Section 1.01. *Definition.* For the purposes of these By-Laws and Articles VII and VIII of the Articles of Incorporation of this Corporation, the term "Subscriber" shall mean any individual 18 years of age or over who:

(1) has a subscription agreement in force in his name or a group identification card bearing his name issued by or on behalf of the Corporation; or

(2) is entitled to benefits under a group contract with the Corporation which provides coverage for all such persons in that group without specifying individual names; or

(3) is entitled to benefits as an eligible dependent of a person described in subsections (1) or (2) of this Section.

Section 1.02. *Classes.* All Subscribers shall constitute a single class for the purposes of voting by class pursuant to any statutory provision requiring a vote by class for any purpose.

ARTICLE II

Meetings of Subscribers

Section 2.01. *Place of Meeting.* All meetings of the Subscribers shall be held at such place within the City

of Philadelphia as is designated in the notice of such meeting by the person authorized by these By-Laws to give such notice.

SECTION 2.02. *Annual Meeting.* The Annual Meeting of the Subscribers shall be held on the fourth Tuesday of February, if not a legal holiday under the laws of Pennsylvania, otherwise on the next succeeding business day not a Saturday, at 6:00 P.M. or such other hour as may be designated in the notice of the meeting. At said meeting the Subscribers then entitled to vote shall elect Directors and shall take action on any matter which may be brought before the meeting under Article IX of these By-Laws. The Chairman shall have the right in his discretion to limit the duration of Subscribers' questions or remarks from the floor to a period of not less than five minutes per Subscriber. If the Annual Meeting shall not have been called and held within six months after the date specified in this Section, any Subscriber may call such meeting at any time thereafter.

SECTION 2.03. *Special Meetings.* Special meetings of Subscribers of the Corporation for any purpose or purposes may be called at any time by the President, by the Board of Directors, or by Subscribers entitled to cast at least 10% of the votes which all Subscribers of the Corporation are entitled to cast at the particular meeting. The Subscribers' petition for such a special meeting shall include the subscription number or the identification number under a group contract of every Subscriber who signs such petition.

At any time, upon written request of any person or persons who have duly called a special meeting, which written request shall state the object of the meeting, it shall be the duty of the Secretary to fix the date of the

meeting to be held at such date and time as the Secretary may fix, not less than ten nor more than 60 days after the receipt of the request, and to give due notice thereof. If the Secretary shall neglect or refuse to fix the date and time of such meeting and give notice thereof, the person or persons calling the meeting may do so.

SECTION 2.04. *Formal Notice of Meetings.* The Secretary shall mail formal notice of every meeting of Subscribers whether Annual or Special to each Subscriber whose address is listed on the records of the Corporation. Where the address of a Subscriber is not so listed, the Secretary shall mail or deliver such notice to the group leader of the group to which such Subscriber belongs, and shall make a diligent effort to insure that the group leader (1) is provided with a copy of the notice for distribution to the Subscriber, and (2) is encouraged to distribute such copy to the Subscriber promptly after receipt thereof. The Secretary may use under this section any class of mail which the Secretary reasonably believes will result in the delivery of substantially all mailed matter to the addressees thereof at least 30 days prior to the day named for the meeting. In addition formal notice of every meeting of Subscribers shall be published in at least two newspapers published in the English language in the City of Philadelphia, one of which shall be the legal newspaper designated by the rules of court for publication of legal notice, at least 45 days prior to the day named for the meeting.

Every formal notice of meeting shall state briefly the purpose or purposes thereof, and no business, other than that specified in such notice and matters germane thereto, shall be transacted at any meeting without further notice to Subscribers not present. The formal notice relating to a meeting of Subscribers at which Directors

are to be elected shall contain the information required by Sections 3.04(h) and 3.06 of these By-Laws.

Whenever the language of a proposed resolution is included in a formal notice of a meeting of Subscribers, the resolution may be adopted at such meeting, with such clarifying or other amendments as do not enlarge its original purpose, without further notice to Subscribers not present.

SECTION 2.05. *Formal Notice to Contain Proxies.* Formal notices of meetings of Subscribers (but not preliminary notices under Section 3.04(d) and (f) of these By-Laws) shall contain a form of proxy which a Subscriber who will be absent from such meeting may use. The form relating to a meeting of Subscribers at which Directors are to be elected shall contain the provisions required by Section 3.06 of these By-Laws. The proxy shall be signed by such Subscriber, and shall include his subscription agreement number or his identification number under his group contract. The proxy agents named in the body of such proxy form shall be three persons selected by the Board of Directors. At a meeting of the Board preceding the mailing and publication of such notice, the Board shall name proxy agents for the ensuing meeting of the Subscribers. If proxy agents are not so selected within 20 days prior to such mailing and publication, the Chairman of the Board may name such proxy agents.

SECTION 2.06. *Quorum, Manner of Acting and Adjournment.* The presence in person (hereinafter defined to include by proxy) of Subscribers entitled to cast 1,000 votes on a particular matter shall constitute a quorum for the purpose of considering such matter. The Subscribers present at a duly organized meeting may continue

to do business until adjournment, notwithstanding withdrawal of enough Subscribers to leave less than a quorum.

If a meeting cannot be organized because a quorum has not attended, the Subscribers present may adjourn the meeting to such time and place as they may determine. At any such adjourned meeting at which a quorum may be present, such business may be transacted as might have been transacted at the meeting as originally called. In case of any meeting called for the election of Directors, those Subscribers who attend the second of such adjourned meetings, though less than a quorum, shall nevertheless constitute a quorum for the purpose of electing Directors. Any meeting at which Directors are to be elected shall be adjourned only from day to day, or for such longer periods not exceeding 15 days each, as the Subscribers present entitled to cast at least a majority of the votes which all members present and voting are entitled to cast, shall direct, until such Directors are elected.

Except as otherwise specified in the Articles or these By-Laws or provided by statute, the acts, at a duly organized meeting, of Subscribers entitled to cast at least a majority of the votes which all Subscribers present and voting are entitled to cast, shall be the acts of the Subscribers.

SECTION 2.07. *Quorum at Adjourned Meetings.* Notwithstanding any contrary provision in these By-Laws, in the case of any meeting called for any other purpose other than the election of Directors, those Subscribers who attend the second of such adjourned meetings, although less than a quorum as fixed in these By-Laws, shall nevertheless constitute a quorum for the purpose of acting upon any resolution or other matter set forth in

the notice of the meeting, if written notice of such second adjourned meeting, stating that those Subscribers who attend shall constitute a quorum for the purpose of acting upon such resolution or other matter, is given to each Subscriber of record entitled to vote at such meeting at least ten days prior to the date named for that meeting.

SECTION 2.08. *Organization.* At every meeting of the Subscribers the Chairman of the Board, or in the case of vacancy in office or absence of the Chairman, one of the following Officers present in the order stated: the Vice Chairman of the Board, the President, the Executive Vice President, the other Vice Presidents in their order of rank as determined from time to time by the Board of Directors, or a Chairman chosen by a majority of the Subscribers present, shall act as presiding officer and the Secretary, or, in his absence, an Assistant Secretary, or in the absence of both the Secretary and Assistant Secretaries, a person appointed by the presiding officer, shall act as Secretary.

SECTION 2.09. *Voting.* Every Subscriber shall be entitled to one vote at every meeting of Subscribers of the Corporation. The vote upon any matter, other than the election of Directors, need not be by ballot unless otherwise directed by the presiding officer. For the purpose of voting for the election of Directors and on any other matter, the presiding officer may require that each Subscriber include his name and his subscription agreement number or his identification number under his group contract on his ballot.

Every Subscriber entitled to vote at a meeting of Subscribers may authorize another person or persons to act for him by proxy; and every reference in these By-Laws to the presence or vote of or action by a Subscriber

shall include the presence or vote of or action taken by a proxy agent of a Subscriber. Every proxy shall be executed in writing by the Subscriber. No proxy shall be valid unless delivered to the Executive Offices of the Corporation, 16th Floor Widener Building, 1333 Chestnut Street, Philadelphia, Pennsylvania 19107, Attention: Corporate Secretary, not later than 4:30 P.M. on the second Friday after the first Tuesday in February, in the case of an Annual Meeting of Subscribers, or on the seventh business day preceding the meeting, in the case of any other meeting of Subscribers. A proxy shall be revocable at will, notwithstanding any other agreement or any provision in the proxy to the contrary, but the revocation of a proxy shall not be effective until written notice thereof has been given to the Secretary of the Corporation. No unrevoked proxy shall be valid after 11 months from the date of its execution. A proxy shall not be revoked by the death or incapacity of the maker, unless, before the vote is counted or the authority is exercised, written notice of such death or incapacity is given to the Secretary of the Corporation. A Subscriber shall not sell his vote or execute a proxy to any person for any sum of money or anything of value.

SECTION 2.10. *Voting Lists.* Any individual who is a Subscriber as shown by the records of the Corporation or by the records of a contracting party shall be entitled to vote in person or by proxy at any meeting of the Subscribers. Whenever it is necessary under these By-Laws to determine the total number of Subscribers of the Corporation as of specific date, such question shall be referred for determination to the consulting actuaries of the Plan, whose determination shall be conclusive. For the purpose of Subscriber petitions under Section 2.03 of this Article and Article IX of these By-Laws the total number

of Subscribers shall be determined at the election of such actuaries either as of the date of the filing of the petition or as of any other date selected by such actuaries within 16 days prior to or after the date of such filing.

SECTION 2.11. *Judges of Election.* In advance of any meeting of Subscribers the Board of Directors may appoint judges of election, who may, but need not, be Subscribers, to act at such meeting or any adjournment thereof. If judges of election are not so appointed, the presiding officer of any such meeting may, and upon the demand of any Subscriber at the meeting and before voting begins, shall appoint judges of election. The number of judges shall be either one or three as determined in the case of judges appointed upon demand of a Subscriber, by the presiding officer. No person who is candidate for office or salaried employee of the Corporation shall act as a judge. In case any person appointed as judge fails to appear or fails or refuses to act, the vacancy may be filled by appointment made by the Board of Directors in advance of the convening of the meeting, or at the meeting by the presiding officer of the meeting.

If judges of election are appointed as aforesaid, they shall determine the number of Subscribers of record and the voting power of each, the Subscribers present at the meeting, the existence of a quorum, the authenticity, validity and effect of proxies, receive votes or ballots, hear and determine all challenges and questions in any way arising in connection with the right to vote, count and tabulate all votes, determine the result, and do such acts as may be proper to conduct the election or vote with fairness to all Subscribers. The judges of election shall perform their duties impartially, in good faith, to the best of their ability, and as expeditiously as is practical. If there are three judges of election, the decision, act or

certificate of a majority shall be effective in all respects as the decision, act or certificate of all.

On request of the presiding officer of the meeting or of any Subscriber, the judges shall make a report in writing of any challenge or question or matter determined by them, and execute a certificate of any fact found by them.

SECTION 2.12. *Determination of Subscribers of Record.* The Board of Directors may fix a time, not more than 70 days prior to the date of any meeting of Subscribers or any adjournment thereof, as a record date for the determination of the Subscribers entitled to notice of, or to vote at, any such meeting, and in such case, if otherwise entitled, only Subscribers of record on the date so fixed, and no others, shall be entitled to notice of, or to vote at, such meeting, notwithstanding any increase or other change in the number of Subscribers on the books of the Corporation after any such record date fixed as aforesaid. The Board of Directors may similarly fix a record date for the determination of Subscribers of record for any other purpose. If no record date is fixed:

(a) The record date for determining Subscribers entitled to notice of or to vote at a meeting of Subscribers shall be at the close of business on the day next preceding the date on which notice is given.

(b) The record date for determining Subscribers for any other purpose shall be at the close of business on the date on which the Board of Directors adopts the resolution relating thereto.

ARTICLE III

BOARD OF DIRECTORS

SECTION 3.01. *Powers.* The Board of Directors shall have full power to conduct, manage, and direct the busi-

ness and affairs of the Corporation, and all powers of the Corporation, except those specifically reserved or granted to the Subscribers by statute or by the Articles or these By-Laws, are hereby granted to and vested in the Board of Directors.

SECTION 3.02. *Qualifications.* Each Director of the Corporation shall be a natural person of at least 18 years of age, and a Subscriber of the Corporation residing within the area served by the Corporation but need not be a resident of Pennsylvania. Upon attaining the age of 75 years, a Director shall thereupon cease to be a Director, but may then or thereafter become a Director Emeritus if appointed pursuant to Section 3.03(e) of this Article. The preceding sentence shall not be applicable to any Directors in office on the date of the original adoption of such sentence and shall not disqualify such a person from eligibility to reelection as a Director after having attained age 75. No more than three of the Directors may be trustees or directors of hospitals: and no more than three may be physicians. No person shall be eligible for election to the Board of Directors or to continue as a Director who is a Provider of services or an employee (other than a physician) of a Provider of services to a Subscriber of this Corporation or his eligible dependents. For the purposes of this Section the term "Provider of Services" shall mean a facility defined as such in Title XVIII of the Social Security Act or any similar facility.

A person who violates Section 3.19(a) of this Article shall not be eligible to continue as a Director. The Board of Directors shall forthwith remove from office any Director who becomes ineligible to continue in office as a Director of the Corporation. If nominations have been called for as provided in these By-Laws, only candidates who have been nominated in accordance with these By-Laws shall be eligible for election.

SECTION 3.03. *Number and Term of Office.*

(a) The Board of Directors shall consist of 34 Elective Directors, and the ex-officio Members provided for in subsection (d) of this Section.

(b) Except as provided in subsection (c) of this Section or in Section 3.10(e) of this Article, each Elective Director shall serve until the third Annual Meeting following his election by the Subscribers and until his successor shall have been elected and qualified, or until his earlier death, resignation or removal.

(c) The terms of Directors to be elected at any meeting of Subscribers called for the election of Directors shall be so staggered that, as nearly as possible, an equal number of Directors shall be elected in successive years.

(d) There shall be the following ex-officio Members of the Board of Directors, who, except in the case of the President and Executive Vice President, shall have the right to vote:

(1) The President

(2) The Executive Vice President

(3) The Chairman of the Consumer Advisory Committee

(4) The Vice Chairman of the Consumer Advisory Committee.

(e) The Board may at its discretion appoint any Member of the Board to the status of a Director Emeritus, if:

(1) The appointment is made with the consent of the Director; and

(2) The Director has served as a Director of the Corporation for not less than ten years.

A Director Emeritus, until his death, resignation or removal, shall have all the rights of a Director, except the right to vote.

(f) At any Annual Meeting the Subscribers shall elect, in addition to Directors elected for three-year terms, a Director to serve for a one-year or a two-year term, as appropriate, to fill the unexpired portion of the term with respect to each vacancy which under Section 3.10(e)(1) or (2) of this Article cannot be filled by the Board of Directors.

SECTION 3.04. *Nominations of Elective Directors.* The Elective Directors shall be nominated in the following manner:

(a) Prior to the Annual Meetings in 1978 and each third year thereafter the Governor of the Commonwealth of Pennsylvania and the Mayor of the City of Philadelphia shall each nominate one eligible person for the office of Elective Director. Prior to the Annual Meetings in 1977 and each third year thereafter the President of the Philadelphia City Council and the Chairman of the Board of Commissioners of Bucks County, Pennsylvania shall each nominate one eligible person for the office of Elective Director. Prior to the Annual Meetings in 1976 and each third year thereafter the Chairmen of the respective Boards of Commissioners of Chester, Delaware and Montgomery Counties, Pennsylvania shall each nominate one eligible person for the office of Elective Director.

(b) The Chairman of the Board shall by the first Tuesday in September, or as soon thereafter as practicable, appoint a Nominating Committee consisting of at least nine members of whom:

(1) two shall be Elective Directors who were nominated for election to the Board by public officials as provided in subsection (a) of this Section, if there are at least two such Elective Directors serving on the Board, and, if not, the Chairman and Vice Chairman of the Consumer Advisory Committee, in that order as required, shall serve.

(2) two at least shall be Subscribers who are not otherwise affiliated with the Corporation or with any Provider of health care services.

(c) The Nominating Committee shall choose a Chairman, who shall notify the public officials specified in subsection (a) of this Section of their right to nominate candidates for the office of Elective Director and shall fix in such notice a date, which shall not be less than three weeks after the giving of such notice, by which the nominations of eligible persons by such public officials shall be made and delivered in writing to the Chairman.

(d) On or before the first Friday following the first Tuesday in September, or as soon thereafter as practicable, the Secretary shall cause to be published in at least two newspapers published in the English language in the City of Philadelphia, one of which shall be the legal newspaper designated by the rules of court for the publication of legal notices, an initial notice of the Annual Meeting of Subscribers, which shall:

(1) State that a Nominating Committee has been appointed and shall set forth the purpose thereof.

(2) Set forth the names of the individuals comprising the Nominating Committee.

(3) Advise the public that any Subscriber may have such Subscriber's name considered by the Nominating Committee by submitting a resume to the Secretary of the Corporation on or before the third Monday of September.

The Secretary shall promptly deliver all such resumes to the Nominating Committee.

(e) Thereafter, the Nominating Committee shall meet, and by the second Monday in October shall submit in writing to the Secretary of the Corporation the names of the eligible persons nominated by public officials pursuant to subsection (a) of this Section and such a number of names of other eligible persons so that the total number of nominations for the office of Elective Director submitted by the Committee shall equal the number of Elective Directors to be elected at the next Annual Meeting of Subscribers as provided in Section 3.03(f) of this Article.

(f) On or before the first Friday following the second Monday of October, or as soon thereafter as practicable, the Secretary shall cause to be published in the manner provided by Subsection (d) of this Section a second notice of the Annual Meeting of Subscribers, which shall:

(1) List the individuals nominated by the Nominating Committee and the public officials pursuant to this Section.

(2) Summarize the provisions of subsection (g) of this Section relating to the procedures for the making of additional nominations.

(g) Additional nominations may be submitted in writing to the Secretary of the Corporation on or before the fourth Monday of November, in the manner in which proxies are filed under Section 2.09 of these By-Laws. Each such nomination shall be in the form of a petition signed by at least 300 Subscribers, shall contain the name of such additional nominee, the name of any proxy agent or agents who will act for Subscribers who desire to support such nominee, and shall include a statement that the nominee is eligible to serve as an Elective Director under the By-Laws together with the subscription agreement numbers or identification numbers under a group contract of the nominee and of all the Subscribers who signed the petition. Endorsed on or accompanying the petition shall be the written acceptance of nomination by the nominee and the written acceptance of designation by the proxy agent or agents named in the petition. A Subscriber may sign as many nominating petitions as there are Directors to be elected.

(h) On or before the second Friday of December, or as soon thereafter as practicable, the Secretary shall publish formal notice of the Annual Meeting of Subscribers in the manner provided by Section 2.04 of these By-Laws. Such notice shall include the names of all individuals duly nominated for the office of Elective Director pursuant to these By-Laws, grouped under Nominating Committee nominees, public official nominees and additional nominees headings, as appropriate.

SECTION 3.05. *Substitute Nominations.* The Board of Directors, at any time before the commencement of balloting, may substitute another candidate for any candidate nominated by the Nominating Committee who for

any reason shall be unavailable for election at the Annual Meeting. If a candidate nominated by a public official pursuant to subsection (a) of Section 3.04 of this Article is unavailable, the Secretary shall request the appropriate public official or officials to submit the name of a substitute candidate, who if eligible shall be substitute nominee.

SECTION 3.06. *Proxies and Proxy Agents.* The form of proxy accompanying the formal notice of a meeting of Subscribers at which Directors are to be elected shall contain the names of the proxy agents designated pursuant to Section 2.05 of these By-Laws, who shall be identified as "Blue Cross Proxy Agents." The formal notice of an Annual Meeting of Subscribers shall state that the Blue Cross Proxy Agents will vote for the Nominating Committee nominees and the public official nominees identified in the notices. The notice shall also state the names of proxy agents for additional nominees, and the notice and form of proxy shall contain instructions as to the method whereby a Subscriber may designate on the form of proxy one or more proxy agents for additional nominees in lieu of the Blue Cross Proxy Agents named in the body of the form of proxy.

SECTION 3.07. *Election.* Except in the case of interim vacancies, Directors shall be elected in the following manner by the Subscribers:

(a) The candidates receiving the highest number of votes, up to the number of Directors to be elected, shall be elected.

(b) In the event that the number of trustees or physicians who receive sufficient votes at any meeting of Subscribers to be elected as Directors shall exceed

the number who may hold office by reason of the limitations on the maximum number of trustees or physicians set forth in Section 3.02 of this Article, then only as many trustees and physicians shall be declared elected as will comply with such limitations. If there are at the time less than three trustees or physicians holding terms which do not expire at such meeting, the trustees or physicians declared elected at such meeting shall be those receiving the highest number of votes of the trustees or physicians who received sufficient votes to be elected as Directors up to the number of such Directors who may be elected by reason of the limitations in Section 3.02 of this Article.

SECTION 3.08. *Organization.* At every meeting of the Board of Directors the Chairman of the Board, or, in the case of a vacancy in the office or absence of the Chairman, one of the following officers present in the order stated: the Vice Chairman of the Board, the President, the Executive Vice President, the other Vice Presidents in their order of rank as determined from time to time by the Board of Directors, or a Chairman chosen by a majority of the Directors present, shall preside; and the Secretary, or, in his absence, an Assistant Secretary, or in the absence of the Secretary and the Assistant Secretaries, any person appointed by the Chairman of the meeting, shall act as Secretary.

SECTION 3.09. *Resignations.* Any Director of the Corporation may resign at any time by giving written notice to the Secretary of the Corporation. Such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein and, unless

otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

SECTION 3.10. *Vacancies.*

(a) The Board of Directors may declare vacant the office of a Director

(1) if he is declared of unsound mind by an order of court, or convicted of felony, or for any other proper cause,

(2) if within 60 days after notice of his election, he does not accept such office either in writing or by attending a meeting of the Board of Directors,

(3) if any Director shall have absented himself from three successive meetings and no satisfactory explanation of such absence shall have been made to the Board, or

(4) if he becomes disqualified pursuant to Section 3.02 of this Article.

(b) The office of any Elective Director who was nominated by a public official pursuant to subsection (a) of Section 3.04 may be declared vacant by the Board of Directors at the end of the first or second year of his term upon the receipt of a written notice from the public official responsible for that nomination requesting that the Board declare the office vacant. The Board of Directors shall then fill the vacancy pursuant to subsection (d) of this Section.

(c) Any interim vacancy or vacancies in the Board of Directors caused by death, resignation, removal in any manner other than under the provisions of Section 3.11 of this Article, disqualification, an increase in the number of Directors, or any other cause, may be filled by a vote

of the majority of the remaining Members of the Board of Directors though less than a quorum, at any regular or special meeting.

(d) If a vacancy occurs by reason of the death, resignation or removal of a Director nominated by a public official designated in subsection (a) of Section 3.04 of this Article, the Board of Directors shall fill the vacancy from among a person or persons nominated in writing by such public official.

(e) Directors elected to fill interim vacancies shall continue in office for the unexpired portion of the term and until their successors shall have been elected and qualified, or until their earlier death, resignation or removal, except in the case of:

(1) a vacancy in the office of a Director whose regular term expires at the third succeeding Annual Meeting, or

(2) a vacancy occurring more than six months before the next annual Meeting in the office of a Director whose regular term expires at the second succeeding Annual Meeting;

In either of the foregoing cases the Board may fill the vacancy only until the next Annual Meeting occurring more than six months after the occurrence of the vacancy, at which time a successor shall be elected by the Subscribers for the balance of the unexpired portion of the term.

SECTION 3.11. *Removal.* At any special or other meeting called for the purpose of removing or electing Directors, the entire Board of Directors, or any individual Director, may be removed from office without assigning any cause, by the vote of Subscribers entitled to cast at

least 10% of the votes which all Subscribers would be entitled to cast at any Annual Meeting or special meeting, provided such vote constitutes a majority vote of those present and voting. In case the Board or any one or more Directors is so removed, new Directors may be elected at the same meeting.

SECTION 3.12. *Place of Meeting.* The Board of Directors may hold its meetings at such place or places within Pennsylvania or elsewhere as the Board of Directors may from time to time appoint, or as may be designated in the notice calling the meeting.

SECTION 3.13. *Organization Meeting.* Immediately after each annual election of Directors or after a meeting at which the entire Board of Directors is elected, the Board of Directors shall meet for the purpose of organization, election of officers, and the transaction of other business, at the place where said election of Directors was held. Notice of such meeting need not be given. Such organization meeting may be held at any other time or place which shall be specified in a notice given as hereinafter provided for special meetings of the Board of Directors.

SECTION 3.14. *Regular Meetings.* Regular meetings of the Board of Directors shall be held at such time and place as shall be designated from time to time by resolution of the Board of Directors. If the date fixed for any such regular meeting is a legal holiday under the laws of the State where such meeting is to be held, then the meeting shall be held on the next succeeding business day, not a Saturday, or at such other time as may be determined by resolution of the Board of Directors. At such meetings, the Directors shall transact such business as may properly be brought before the meeting. Notice

of regular meetings need not be given unless required by law or these By-Laws.

SECTION 3.15. *Special Meetings.* Special meetings of the Board of Directors shall be held whenever called by the Chairman, by the Vice Chairman, by the President or by two or more of the Elective Directors. Notice of each such meeting shall be given to each Director by telephone or in writing at least 24 hours (in the case of notice by telephone) or 48 hours (in the case of notice by telegram) or five days (in the case of notice by mail) before the time at which the meeting is to be held. Every such notice shall state the time and place of the meeting.

Notice of any meeting of the Board of Directors during any emergency resulting from warlike damage, or an attack on the United States, or any nuclear or atomic disaster, shall be given only to such of the Directors as it may be feasible to reach at the time and by such means as may be feasible at the time, including publication or radio. To the extent required to constitute a quorum at any meeting of the Board of Directors during such an emergency, the officers of the Corporation who are present shall be deemed, in order of rank and within the same rank in order of seniority as determined, from time to time, by the Board of Directors, Directors for such meeting.

SECTION 3.16. *Quorum, Manner of Acting, and Adjournment.* Except as otherwise provided in Section 3.15 of this Article, 13 Elective Directors shall be present at each meeting in order to constitute a quorum for the transaction of business. Except as otherwise specified in the Articles or these By-Laws or provided by statute, the acts of a majority of the Directors present at a duly organized meeting shall be the acts of the Board of

Directors. In the absence of a quorum, a majority of the Directors present may adjourn the meeting from time to time until a quorum is present. The Directors shall act only as a Board, and the individual Directors shall have no power as such, except that any action which may be taken at a meeting of the Board may be taken without a meeting, if a consent or consents in writing setting forth the action so taken shall be signed by all of the Elective Directors in office filed with the Secretary of the Corporation.

SECTION 3.17. *Executive and Other Committees.*

(a) The Board of Directors, by resolution adopted by a majority of the Directors in office, may designate an Executive Committee and one or more other committees. The Executive Committee and the Audit Committee shall each consist of at least seven Directors, and, except as otherwise provided in these By-Laws, any other committees shall consist of three or more Directors. The Executive Committee shall include at least two Elective Directors who were nominated for election to the Board by public officials as provided in Section 3.04(a) of this Article, if there are two such Elective Directors serving on the Board. Each committee of the Board shall serve at the pleasure of the Board. The Board may designate one or more Directors as alternate members of any committee to replace any absent or disqualified member at any meeting of the committee. In the event of absence or disqualification of a member of any committee, and of the alternate or alternates, if any, designated for such member, the member or members thereof present at any meeting and not disqualified from voting, whether or not he or they constitute a quorum, may unanimously appoint another Director to act at the meeting in the place of any such absent or disqualified member.

(b) The Executive Committee shall have and may exercise all of the powers and authority of the Board of Directors except that the Executive Committee shall not have any power or authority as to the following:

(1) The submission to Subscribers of any action requiring approval of Subscribers [under these By-Laws or the Non-profit Corporation Law of 1972].

(2) The filing of vacancies in the Board of Directors.

(3) The adoption, amendment or repeal of the By-Laws.

(4) The amendment or repeal of any resolution of the Board.

(c) The Audit Committee may include any Member of the Board of Directors of the Corporation except the President and Executive Vice President of the Corporation. The Audit Committee shall review all reports of the firm of independent certified public accountants selected by the Board and such other matters as may from time to time be referred to this Committee by the Board, by the Executive Committee, by the officers or by the auditors, and shall annually review the adequacy of bonding arrangements under Section 6.06 of these By-Laws and of all arrangements for the receipt, custody and disbursement of funds including banking and custody resolutions and authorizations, and shall duly report their findings and recommendations as appropriate.

(d) The Personnel Committee shall consider and make recommendations to the Board of Directors concerning:

(1) All salaries requiring Board approval except those of officers designated by resolution of the Board.

(2) All officers to be elected by the Board.

(3) The operation and provisions of the Revised Retirement Plan (sometimes referred to as the Pension Plan).

(4) Any other matters which the Board of Directors shall refer to the Personnel Committee.

(e) No committee of the Board, other than the Executive Committee, shall, pursuant to resolution of the Board or otherwise, exercise any of the powers or authority vested by law in the Board of Directors as such, but any committee of the Board may make recommendations to the Board of Directors or to the Executive Committee concerning the exercise of such powers and authority.

(f) A majority of the Directors in office designated to any committee, or Directors designated to replace them as provided in this Section, shall be present at each meeting of any such committee to constitute a quorum for the transaction of business and the acts of a majority of the Directors in office designated to a committee or their replacements shall be the acts of the committee.

(g) Each committee shall keep regular minutes of its proceedings and report promptly such proceedings to the Board of Directors when required for approval or disapproval; but any such disapproval shall not affect the rights of third parties accruing prior to such disapproval.

(h) Those portions of Sections 3.14, 3.15 and 3.16 of this Article, as may be applicable, shall apply to committees of the Board of Directors.

SECTION 3.18. *Consumer Advisory Committee.*

(a) There shall be a Consumer Advisory Committee to the Board which shall consist of seven members, who

shall have the qualifications prescribed for Directors by Section 3.02 of this Article and who shall serve without compensation, one each to be appointed by the Governor of Pennsylvania, the Mayor of the City of Philadelphia, the President of the Philadelphia City Council, and the Chairmen of the respective Boards of Commissioners of the Counties of Bucks, Chester, Delaware and Montgomery, Pennsylvania. The terms of the members of the Consumer Advisory Committee to be appointed in July 1973 shall extend to the Annual Meeting in 1975. Thereafter the seven appointed members of the Consumer Advisory Committee shall be appointed annually for terms of one year extending from one Annual Meeting to the next when their membership on the Committee shall then terminate unless they are reappointed.

(b) The primary function and concern of the Committee shall be to advise the Board of Directors from time to time how, in the opinion of the Committee, the Plan can best:

(1) Improve its coverage of, and service to, its Subscribers.

(2) Obtain for its Subscribers high quality health care at minimum cost.

The Committee shall report only to the Board of Directors, except that it may also present a report of its activities at any Annual Meeting of the Subscribers. Copies of the Committee's reports to the Board may be sent only to the Insurance Commissioner, and a copy of any report by the Committee to an Annual Meeting of the Subscribers shall be delivered to the Secretary of the Corporation not less than two weeks prior to such Meeting.

(c) There shall be a Chairman and Vice-Chairman of the Committee each of whom shall be one of the seven members of that Committee appointed by public officials under subsection (a) of this Section and not a member of the Committee elected under subsection (d) of this Section and who shall be elected only by the vote of at least four members of that Committee appointed by public officials under subsection (a) of this Section.

(d) The seven appointed members of the Committee shall be empowered by vote of at least four members to elect to its membership not more than seven additional members from Consumer Groups as it deems appropriate, and such additional members shall serve until the next Annual Meeting.

(e) The Committee shall meet at least quarterly with a senior officer of the Corporation present, and after such meeting promptly submit the minutes of such meeting and report its recommendations, if any, in writing to the Board of Directors through the Chairman or Vice Chairman of the Committee.

(f) The Chairman of the Board shall call any organizational meeting of the Committee by letters to each of the seven Committee members appointed under subsection (a) of this Section. The quorum for such organizational meeting shall consist of at least five of the appointed members. The quorum for all other meetings of the Committee shall consist of a majority of the then members of that Committee. Those portions of Sections 3.14, 3.15 and 3.16 of this Article, as may be applicable and not inconsistent with the provisions of this section, shall apply to the Consumer Advisory Committee.

SECTION 3.19. *Interested Directors or Officers; Quorum.*

(a) No Director who is a physician or a hospital employee, officer, trustee, director or affiliate shall participate directly on behalf of the Corporation or on behalf of a Provider of health care services in the negotiation of any contract between the Corporation and a Provider or vote on the question of the authorization, approval or ratification of such a contract.

(b) No contract or transaction between the Corporation and one or more of its Directors or Officers, or between the Corporation and any other corporation, partnership, association, or other organization in which one or more of its Directors or Officers are directors or officers, or have a financial interest, shall be void or voidable solely for such reason, or solely because the Director or Officer is present at or participates in the meeting of the Board which authorizes the contract or transaction, or solely because his or their votes are counted for such purpose, if:

(1) The material facts as to his relationship or interest and as to the contract or transaction are disclosed to the Board of Directors and the Board in good faith authorizes the contract or transaction by the affirmative votes of a majority of the disinterested Directors, even though the disinterested Directors are less than a quorum; or

(2) The contract or transaction is fair as to the Corporation as of the time it is authorized, approved or ratified, by the Board of Directors.

(c) Common or interested Directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors which authorizes a contract or transaction specified in this Section.

Exhibit 2

ARTICLE IV

Notice—Waivers—Meetings

Section 4.01. *Notice, What Constitutes.* Except as provided in Section 2.04 of these By-Laws whenever written notice is required to be given to any person under the provisions of the Articles, these By-Laws, or the Nonprofit Corporation Law of 1972, it may be given to such person, either personally or by sending a copy thereof through the mail, or by telegraph, charges prepaid, to his address appearing on the books of the Corporation, or in the case of directors supplied by him to the Corporation for the purpose of notice. If the notice is sent by mail or by telegraph, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail or with a telegraph office for transmission to such person. A notice of a meeting shall specify the place, day and hour of the meeting.

When a meeting is adjourned, it shall not be necessary to give any notice of the adjourned meeting or of the business to be transacted thereat, other than by announcement at the meeting at which such adjournment is taken.

Section 4.02. *Waivers of Notice.* Whenever any written notice is required to be given under the provisions of the Articles, these By-Laws, or the Nonprofit Corporation Law of 1972, a waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Except in the case of a special meeting of Subscribers, neither the business to be transacted at, nor the purpose of, the meeting need be specified in the waiver of notice of such meeting.

Exhibit 2

Attendance of a person at any meeting shall constitute a waiver of notice of such meeting, except where a person attends a meeting for the express purpose of objecting to the transaction of any business because the meeting was not lawfully called or convened.

Section 4.03. *Exception to Requirement of Notice.* Wherever any notice or communication is required to be given to any person under the provisions of the Articles, of these by-laws or the Nonprofit Corporation Law of 1972, or by the terms of any agreement or other instrument or as a condition precedent to taking any corporate action, and communication with such person is then unlawful, the giving of such notice or communication to such person shall not be required and there shall be no duty to apply for a license or other permission to do so.

Section 4.04. *Conference Telephone Meetings.* One or more Directors may participate in a meeting of the Board, or a committee of the Board, by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation in a meeting pursuant to this Section shall constitute presence in person at such meeting.

ARTICLE V

Officers

Section 5.01. *Number, Qualifications and Designation.* The Officers of the Corporation shall be a Chairman of the Board, one or more Vice Chairmen of the Board, a President, an Executive Vice President, one or more other Vice Presidents, a Treasurer, a Secretary and such other officers as may be elected in accordance with the provisions of Section 5.03 of this Article. Any two or more offices may be held by the same person except that no

person may hold more than one of the following offices: Chairman of the Board, Vice Chairman of the Board, President, Executive Vice President, Treasurer and Secretary. The Officers, except the Treasurer, shall be natural persons of full age; the Treasurer, however, may be a corporation, but if a natural person shall be of full age.

SECTION 5.02. *Election and Term of Office.* The Officers of the Corporation shall be elected annually by the Board of Directors, and each such Officer shall hold his office until the next annual organization meeting of Directors and until his successor shall have been duly chosen and qualified, or until his earlier death, resignation, or removal. The election or appointment of an officer shall not of itself create any contract right to employment for any term, it being the intention of these By-Laws that all officers shall serve at the pleasure of the Board of Directors.

SECTION 5.03. *Subordinate Officers, Committees and Agents.* The Board of Directors may from time to time elect such other officers and appoint such committees, employees or other agents as the business of the Corporation may require, including one or more Assistant Vice Presidents, one or more Assistant Secretaries, and one or more Assistant Treasurers, each of whom shall hold office for such period, have such authority, and perform such duties as are provided in these By-Laws, or as the Board of Directors may from time to time determine. The Board of Directors may delegate to any Officer or committee the power to retain or appoint employees or other agents, or committees thereof, and to prescribe the authority and duties of such persons. At the annual organization meeting of the Board of Directors, the Board shall appoint a General Counsel and a firm of independent certified public

accountants for the Corporation to serve at the pleasure of the Board.

SECTION 5.04. *Resignations.* Any Officer or agent may resign at any time by giving written notice to the Board of Directors or to the President or the Secretary of the Corporation. Any such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

SECTION 5.05. *Removal.* Any Officer, committee, employee or other agent of the corporation may be removed, either for or without cause, by the Board of Directors or other authority which elected, retained or appointed such Officer, committee or other agent whenever in the judgment of such authority the best interests of the Corporation will be served thereby, but such removal shall be without prejudice to the contract rights, if any, of persons so removed.

SECTION 5.06. *Vacancies.* A vacancy in any office because of death, resignation, removal, disqualification, or any other cause, shall be filled by the Board of Directors and if the office is one for which these By-Laws prescribe a term, shall be filled for the unexpired portion of the term.

SECTION 5.07. *General Powers.* All Officers of the Corporation, as between themselves and the Corporation, shall, respectively, have such authority and perform such duties in the management of the property and affairs of the Corporation as may be determined by resolution or orders of the Board of Directors, or in the absence of

controlling provisions in a resolution or orders of the Board of Directors, as may be provided in these By-Laws.

SECTION 5.08. *Chairman.* The Chairman of the Board shall preside at all meetings of the Board of Directors and of the Subscribers of the Corporation. He shall act as liaison between the Board of Directors and the President of the Corporation with particular reference to the formulation and implementation of Corporate policy in matters affecting the Corporation, the Subscribers, the Insurance Department of the Commonwealth and contracts with hospitals and the public generally. He shall submit to the Board nominations of Directors to serve on the Executive Committee, the Audit Committee and the Personnel Committee, and on such other Committees of the Board as may exist from time to time. He shall serve without compensation and shall not be associated with or employed by any hospital in any capacity. He or his designee shall also act as liaison between the Consumer Advisory Committee, the Corporation and the Board of Directors, and as such may attend all meetings of that Committee.

SECTION 5.09. *Vice Chairmen.* In the absence of the Chairman, or in the event of his inability or refusal to act, the Vice Chairmen, in the order of their rank as determined from time to time by the Board of Directors, shall exercise all the powers and perform all the duties of the Chairman.

SECTION 5.10. *President.* The President shall be the chief executive officer of the Corporation and shall assist the Chairman of the Board in the formulation of Corporation policy for submission to the Board or the Executive Committee and be responsible for its implementation.

He may sign on behalf of the Corporation any documents or instruments which the Board of Directors or the Executive Committee have authorized to be executed, except in cases where the signing and execution thereof shall be expressly delegated by the Board of Directors or by these By-Laws to some other Officer or agent of the Corporation, or shall be required by law to be otherwise signed or executed; and in general, he shall perform all duties incident to the office of President in accordance with the provisions of this Article, and such other duties as may be prescribed by the Board of Directors or the Executive Committee from time to time. He shall preside at all meetings of the Executive Committee.

SECTION 5.11. *Executive Vice President.* The Executive Vice President shall perform such duties as from time to time may be assigned to him by the President, the Board of Directors or the Executive Committee. In the absence of the President or in the event of his inability or refusal to act, the Executive Vice President shall perform the duties of President and when so acting shall have all the powers, and be subject to all the restrictions upon the President.

SECTION 5.12. *Vice Presidents.* In the absence of the President and the Executive Vice President or in the event of their inability or refusal to act, the Vice Presidents in order of their rank, as determined from time to time by the Board of Directors, shall perform the duties of the President and Executive Vice President and when so acting shall have all the powers of, and be subject to all the restrictions upon, the President or Executive Vice President. Vice Presidents shall perform such other duties as from time to time may be assigned to them by the President, the Executive Vice President, the Board of Directors or the Executive Committee.

SECTION 5.13. *The Treasurer.* The Treasurer shall have or provide for the custody of the funds or other property of the Corporation and shall keep a separate book account of the same to his credit as Treasurer; shall collect and receive or provide for the collection and receipt of moneys earned by or in any manner due to or received by the Corporation; shall deposit all funds in his custody as Treasurer in such banks or other places of deposit as the Board of Directors may from time to time designate; shall, whenever so required by the Board of Directors, render an account showing his transactions as Treasurer, and the financial condition of the Corporation; and, in general, shall discharge such other duties as may from time to time be assigned to him by the Board of Directors, the Executive Committee, the President, or the Executive Vice President. In the absence of the Treasurer or his inability to act, his duties shall be performed by any Assistant Treasurer.

SECTION 5.14. *Secretary.* The Secretary shall keep the minutes of the meetings of the Subscribers of the Corporation and of the Board of Directors in one or more books provided for that purpose; shall notify Members of the Board of Directors of their election; shall see that all notices are duly given in accordance with the provisions of these By-Laws; shall be custodian of the corporate records and of the seal of the Corporation and see that the seal of the Corporation is affixed to all instruments and documents, the execution of which has been authorized by the Board of Directors or the Executive Committee; shall keep a record of the post office address of each Director; and in general shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the President, the Executive Vice President, the Board of Directors or the Executive

Committee. In the absence of the Secretary or his inability to act, his duties shall be performed by any Assistant Secretary.

SECTION 5.15. *Assistant Treasurers and Assistant Secretaries.* The Assistant Treasurers and Assistant Secretaries shall perform such duties as from time to time shall be assigned to them by the Treasurer or Secretary, respectively, or by the President, the Executive Vice-President, the Board of Directors or the Executive Committee.

SECTION 5.16. *Salaries.* The salaries of the Officers elected by the Board of Directors shall be fixed from time to time by the Board of Directors or by such Officer as may be designated by resolution of the Board. The salaries or other compensation of any other officers, employees and other agents shall be fixed from time to time by the Officer or committee to which the power to elect such officers or to retain or appoint such employees or other agents has been delegated pursuant to Section 5.03 of this Article. No Director shall receive any salary or other compensation for his services as such. Officers of the Corporation, excluding the Chairman of the Board and the Vice Chairman of the Board, may receive compensation for their services as Officers of the Corporation.

ARTICLE VI

CONTRACTS, LOANS, CHECKS, DEPOSITS AND INVESTMENTS

SECTION 6.01. *Contracts.* The Board of Directors may authorize any Officer or agent to enter into any contract or to execute and deliver any subscription agreement or instrument in the name of and on behalf of the Corpora-

tion, and such authority may be general or confined to specific instances.

SECTION 6.02. *Loans.* No loans shall be contracted on behalf of the Corporation and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the Board of Directors.

SECTION 6.03. *Checks.* All checks, drafts, bills of exchange or other orders in writing for the payment of money, notes or other evidences of indebtedness issued in the name of the Corporation, shall be signed in such manner, as the Board of Directors may from time to time direct.

SECTION 6.04. *Deposits.* All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Directors may from time to time direct.

SECTION 6.05. *Investments.* The funds of the Corporation equal at least to its reserves shall, subject to the provisions of Chapter 61 of Title 40 of the Consolidated Pennsylvania Statutes (relating to hospital plan corporations) or amendments thereto, be invested in compliance with the requirements for the investment of the capital and reserves of life insurance companies. The funds of the Corporation equal to its surplus shall, subject to the said Act or amendments thereto, be invested in compliance with the requirements for the investment of surplus of life insurance companies.

SECTION 6.06. *Bonds.* All officers and employees shall give bond for the faithful discharge of their duties in

such sum and with such surety or sureties as the Board of Directors shall require.

SECTION 6.07. *Annual Report of Directors.* The Board of Directors shall present annually to the Subscribers at the Annual Meeting a Report, verified by the President and Treasurer or by a majority of the Directors, showing in appropriate detail the following:

(1) The assets and liabilities of the Corporation as of the end of the fiscal year immediately preceding the date of the Report.

(2) The principal changes in assets and liabilities during the year immediately preceding the date of the Report.

(3) The revenue or receipts of the Corporation, both unrestricted and restricted to a particular purpose, for the year immediately preceding the date of the Report.

(4) The expenses or disbursements of the Corporation, for both general and restricted purposes, during the year immediately preceding the date of the Report.

(5) The estimated number of Subscribers of the Corporation as of the date of the Report, together with a statement of increase or decrease in such number during the year immediately preceding the date of the Report.

The annual Report of the Board of Directors or other body shall be filed with the minutes of the meeting of the Subscribers.

Exhibit 2

ARTICLE VII

Indemnification of Directors, Officers, Etc.

Section 7.01. *Directors and Officers; Third Party Actions.* The Corporation shall indemnify any Director or Officer of the Corporation who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the Corporation) by reason of the fact that he is or was a representative of the Corporation (which, for the purposes of this Article, shall mean a Director, Officer, employee or agent of the Corporation, or a person who is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise) against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner he reasonably believed to be in, or not opposed to, the best interests of the Corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in, or not opposed to, the best interests of the Corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

Exhibit 2

Section 7.02. *Directors and Officers; Derivative Actions.* The Corporation shall indemnify any Director or Officer of the Corporation who was or is a party or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that he is or was a representative of the Corporation, against expenses (including attorneys' fees) actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in, or not opposed to, the best interests of the Corporation and except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable for negligence or misconduct in the performance of his duty to the Corporation unless and only to the extent that the court of common pleas of the county in which the registered office of the Corporation is located or the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses which the court of common pleas or such other court shall deem proper.

Section 7.03. *Employees and Agents.* To the extent that a representative of the Corporation who neither was nor is a Director or Officer of the Corporation has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in Sections 7.01 and 7.02 of this Article or in defense of any claim, issue or matter therein, he shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by him in connection therewith. Such a representa-

tive shall also be indemnified by the Corporation in any other circumstances to any extent if the Corporation would be required by Section 7.01 or 7.02 of this Article to indemnify such person in such circumstances to such extent if he were or had been a Director or Officer of the Corporation.

SECTION 7.04. *Procedure for Effecting Indemnification.* Indemnification under Sections 7.01, 7.02 or 7.03 of this Article shall be made when ordered by court (in which case the expenses, including attorneys' fees, of the representative in enforcing such right of indemnification shall be added to and be included in the final judgment against the Corporation) and may be made in the specific case upon a determination that indemnification of the representative is required or proper in the circumstances because he has met the applicable standard of conduct set forth in Section 7.01 or 7.02 of this Article. Such determination shall be made:

(1) By the Board of Directors by a majority vote of a quorum consisting of Directors who were not parties to such action, suit or proceeding,

(2) If such a quorum is not obtainable, or, even if obtainable, a majority vote of a quorum of disinterested Directors so directs, by independent legal counsel in a written opinion, or

(3) By the Subscribers.

SECTION 7.05. *Advancing Expenses.* Expenses (including attorneys' fees) incurred in defending a civil or criminal action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding, upon authorization by the Board of Directors in a specific case upon receipt of an

undertaking by or on behalf of a Director or Officer to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Corporation as required in this Article or authorized by law and may be paid by the Corporation in advance on behalf of any other authorized representative when authorized by the Board of Directors upon receipt of a similar undertaking.

SECTION 7.06. *Scope of Article.* Each person who shall act as an authorized representative of the Corporation shall be deemed to be doing so in reliance upon such rights of indemnification as are provided in this Article.

The indemnification provided by this Article shall not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any agreement, vote of Subscribers or disinterested Directors, statute or otherwise, both as to action in his official capacity and as to action in another capacity while holding such office or position, and shall continue as to a person who has ceased to be an authorized representative of the Corporation and shall inure to the benefit of the heirs and personal representatives of such a person.

ARTICLE VIII

MISCELLANEOUS

SECTION 8.01. *Description of Seal.* The seal of the Corporation shall be circular in form, with the name of the Corporation in the circumference and the words and figures "Incorporated—1938" in the center.

SECTION 8.02. *Conflict of Interest Procedure.* Annually the Officers of the Corporation shall prepare and submit a conflict of interests questionnaire to all of the

Directors, Officers and management employees of the Corporation, who shall respond to the questionnaire by disclosing all of their relevant outside interests, memberships and affiliations.

SECTION 8.03. *Rules of Order.* The rules contained in the then current edition of Roberts' Rules of Order, as revised from time to time, shall govern the Corporation in all cases to which they are applicable and in which they are not inconsistent with these By-Laws and any special rules of order the Corporation may adopt.

ARTICLE IX

FUNDAMENTAL CHANGES; AMENDMENTS

SECTION 9.01. *Subscriber Initiated Action.* Any of the following plans or other corporate action may be proposed by petition of 10% of the Subscribers entitled to vote at an election of Directors, which petition shall be directed to the Board of Directors and filed with the Secretary of the Corporation:

(a) The amendment of the Articles or the adoption, amendment and repeal of these By-Laws.

(b) A plan of sale, lease or exchange of assets under 15 Pa. C. S. § 7930.

(c) A plan of merger, consolidation, division or conversion.

(d) The voluntary dissolution of the Corporation.

SECTION 9.02. *Action Requiring Subscriber Approval.* Except as provided in Section 9.03 of this Article, any plan or other corporate action specified in Section 9.01 of this Article, after having been proposed either by the

Board of Directors or by petition of Subscribers, shall be submitted to a meeting of Subscribers (to be held not more than 60 days after the receipt of a petition, in the case of a meeting of Subscribers to consider and take action on any matter proposed by petition under Section 9.01 of this Article), and shall be deemed adopted by the Corporation when, and only when, approved by the affirmative vote of a majority of Subscribers present in person or by proxy and voting at any regular or special meeting of Subscribers called and held as provided in Article II of these By-Laws, and approved in writing by the Insurance Commissioner and the Governor of the Commonwealth of Pennsylvania.

SECTION 9.03. *Amendments to By-Laws by Board.* The Board of Directors shall have the full authority vested by law in the Board of Directors of a corporation without members to adopt, amend and repeal By-Laws, which action shall require the affirmative vote of two-thirds of the Board of Directors of the Corporation present at any regular or special meeting of Directors at which a quorum is present. Such proposed amendment, repeal or new By-Laws, or a summary thereof, shall be set forth in any notice of such meeting whether regular or special.

Exhibit 3

INTER-PLAN SERVICE BENEFIT BANK

The Inter-Plan Service Benefit Bank is a mechanism through which each Blue Cross Plan (and Health Service, Incorporated) may authorize hospital care benefits for its subscribers when they are admitted as in-patients to Contracting Hospitals of another Blue Cross Plan. The Bank, operated by the Blue Cross Association, serves as coordinator between the Home Plan in which the patient is enrolled as a member, and the Host Plan serving the area in which the hospital is located, in the provision of and payment for covered services.

The amount and kind of care to be provided to a subscriber hospitalized out-of-area is determined by messages exchange between the Host and Home Plans, using the telecommunications system of the Blue Cross Association. However, approval by the Home Plan is specifically limited to the: (1) confirmation of the patient's eligibility for benefits; (2) determination of the number of days during which care may be rendered, according to the benefit days specified in the member's certificate, and prior utilization; (3) designation of the scope of covered ancillary services, as specified in a Host Plan certificate approved for Bank use; and (4) exercise of its option to authorize the Host Plan to provide and pay for service benefits in maternity cases if Host Plan certificates provide only an indemnity allowance for maternity care. Except for the above Home Plan prerogatives, the out-of-area patient is treated as though he were a member of the Host Plan.

The Bank reimburses Host Plans the exact amount of their payments to hospitals and, in turn, Home Plans reimburse the Bank in accordance with a formula which is designed to produce adequate funds to cover both payments to Host Plans and operating costs. The Bank pays Host Plans $3.00 per case to cover claims administration

Exhibit 3

costs, and a like charge is paid to the Bank by Home Plans.

The affairs of the Bank are directed by a Bank Committee appointed by and responsible to the Board of Governors of the Blue Cross Association. Regulations and administrative details essential to the effectiveness of the system, are specifically stated in a Bank Agreement under which each Plan participating in the Bank agrees to comply with established policy and procedure, and commits itself to be responsible for any failure to do so.

Health Service, Incorporated participates in the Bank as a Home Plan only. It becomes involved in Bank cases when a direct-pay subscriber, or member of a National Account group, enrolled by Health Service, Incorporated is hospitalized and responsibility for administration of the Health Service Contract in force is not assigned to and assumed by a particular Blue Cross Plan. When a Plan assumes responsibility for a National Account group, the hospitalization of an enrolled member of the group is reported to that Home Plan and not to Health Service, Incorporated.

In general, the Bank serves as a communications center for the exchange of information between Host and Home Plans which pertain to the provision of hospital care to Blue Cross subscribers, and it serves as a clearinghouse for the money used to pay for such care. Its organization provides the machinery for reviewing and adjudicating any disputes which arise and relate to both these important activities.

LICENSE PROGRAM, APPROVAL PROGRAM, SPECIAL OBLIGATIONS OF MEMBERSHIP AND PLAN PERFORMANCE

This memo and attachments contain a brief explanation of the relationships among the License Program, Approval Program, Special Obligations of Membership and Plan Performance.

License Program

The License Program has a dual purpose: (1) to protect the Blue Cross name and symbol from infringements by third parties; and (2) to assure proper usage of the Blue Cross name and symbol by licensed Blue Cross Plans. With the assumption by BCA of the ownership of the name and mark, effective July 1, 1972, BCA entered into new written license agreements with each Blue Cross Plan which permit the Plan to use the Blue Cross name and symbol within its geographic area so long as it adheres to license requirements of general application. These requirements are set forth in Attachment "1." Such requirements are the same as those contained in the prior license agreements between AHA and Plans. The license requirements may be revised only upon the affirmative vote of three-fourths (¾) of the Plans and three-fourths (¾) of the total weighted vote of all Plans.

In addition, licensed Plans are required to display the name and mark in such form, style and manner as shall be specifically prescribed by BCA in regulations of general application to prevent the impairment of the distinctiveness of the name and mark and the good will pertaining thereto. The Plan is also required to display such legends, markings and notices as BCA may request in order to give appropriate notice of any trademark or

trade name. Such license regulations to prevent impairment of distinctiveness may be changed upon a two-third (⅔) vote of the whole Board preceded by at least sixty (60) days prior written notice to regular Member Blue Cross Plans of any proposed changes.

Further, the Plan is required to submit data annually to BCA or at other times upon the written request of BCA which demonstrates its compliance with the requirements of the License Agreement.

The license of any Plan may not be terminated except for failure to meet the license requirements of general application, failure to comply with the regulations of general application with regard to the display of the marks and/or failure to submit required data.

The License Program is administered by BCA's Legal and Corporate Division on the basis of data collected through the Approval Program, both at the time of submission of the reapproval application and in the course of Plan visitations.

Approval Program

The Approval Program dates back to 1933. Its purpose was to assure that standards of performance were maintained to protect the interests of the public and of hospitals. During AHA's administration, standards were strengthened and clarified on a number of occasions. The administration of this program was likewise assumed by BCA, effective July 1, 1972. A copy of the Approval Program as revised is attached to this memo. Only Plans that are licensed are eligible to be approved. Only Plans which are approved by BCA are awarded an approval certificate and are entitled to refer to themselves as "Approved" Blue Cross Plans. Approval standards are broad, general principles which equate roughly with rules

of "good citizenship" for Blue Cross Plans. While the approval standards contain all of the license requirements of general application, they are more comprehensive and deal with additional matters such as financial responsibility, not included among the license requirements.

Plans may not be approved and yet be licensed. Approval is a condition of eligibility for initial and continued membership in the Association.

Approval is granted annually by the BCA Board on the basis of data regularly submitted by Plans. Plans are visited on a three year cycle for the purpose of reviewing supplementary information and monitoring Plan compliance with license regulations. The Approval Program, like the License Program, is administered by the Legal and Corporate Division. The Board appointed Plan Approval Committee has two functions: (1) to make recommendations to the Board with regard to Plan approval applications; and (2) to make recommendations for changes in the approval standards. At the board's request, the Committee has devoted itself first to developing a recommended change in Approval Standard #1 concerning majority public representation; its next effort will be to make recommendations with regard to Approval Standard #4 on financial responsibility; these efforts to be followed by a general review and recommendations with regard to the remaining standards and any proposed additions thereto.

Upon the assumption by BCA of the administration of the Approval Program, Member Plans voted to require compliance with the standards of the Approval Program as a special obligation of membership. As such, any changes in the approval standards require approval of the Board and the affirmative two-thirds (⅔) weighted vote of Member Plans.

SPECIAL OBLIGATIONS OF MEMBERSHIP

Eligibility for Regular Membership in the Association (Article III, Section I) requires that "Each Blue Cross Plan . . . has been and continues to be formally approved by the Blue Cross Association. . . ." Each Regular Member is obligated to pay monthly dues and marketing service charges (Article III, Section 2). Plans must also use their best efforts to cooperate and support BCA in the achievement of its obligations and purposes and to abide by the intent and spirit of the Association's By-Laws (Article III, Section 3 (g)).

Special obligations are set forth in Article III, Section 3. Originally, subparagraph (a) bound Plans to participate in the Service Benefit Bank Agreement, Transfer Agreement, the Local Benefit Agreement for National Accounts and the National Advertising Program. In order to avoid the necessity of reprinting the By-Laws at times when other obligations might be added, the Plans adopted an amendment to the By-Laws on July 14, 1971 whereby other programs and procedures as may be approved by the Board from time to time and adopted by the affirmative vote of the Regular Members entitled to ⅔ (two-thirds) of the weighted votes could be made obligations of membership. In this fashion, there was added an obligation of membership, effective October 1, 1971, requiring each Regular Member to adopt and implement a conflict of interest policy and procedure following BCA guidelines contained in memorandum dated January 15, 1971. Subsequently, in connection with the transfer of the licensure and approval programs from AHA to BCA, the Members added another special obligation of membership requiring compliance with the standards of the present "Approval Program for Blue Cross Plans" and as it may be amended from time to time on approval of the Board and the affirmative ⅔ (two-thirds) weighted vote of Member Plans.

Over the years, in actions pursuant to the provisions of subparagraphs (b), (c), and (d), the Board of Governors has approved various benefit patterns embodied in the National Account Contract and numerous riders, the last one dealing with "abortion" benefits. In the same manner, the provision of service benefits for out-of-hospital prescription drugs was accomplished (June 23, 1967). Similarly, the Board has approved the equalization document and various amendments.

PLAN PERFORMANCE PROGRAM

A summary of the more recent history of BCA's Plan Performance activity may be helpful in understanding the performance function itself and its relationship to the License and Approval Programs.

At the August 23, 1964 Board of Governors meeting, the Board supported the re-creation of the Plan Performance Review function and the establishment of a seven man Plan Performance Review Committee. No conflict with or duplication of AHA efforts was deemed to be involved in AHA's handling of the Approval Program. At the outset, the proposed review program had "at least three basic purposes: (1) through periodic review to identify problems for individual Plans which would affect adversely other Plans and to provide corrective assistance; (2) to assist Plans in maintaining their AHA approved status; and (3) to review membership status in the BCA with particular reference to the special obligations of membership."

At the Executive Committee meeting of August 20, 1970, in dealing with the problem of diversification, it was voted that "present or contemplated diversification activity be taken into account as part of Plan Performance Reviews." The resolution contemplated that "consultation and advice will be available not only through contact with

BCA staff apart from and at the time of a Plan Performance Review, but also directly through the Executive Committee."

At the Executive Committee meeting of October 19-20, 1970, among the functions of the committee described was "to review methodolgy of Plan Reviews, assist staff in making the Plan Reviews more meaningful and of maximum assistance to the Plans, evaluate proposed standards of Plan Performance and make recommendations for adoption of such standards by the Board of Governors, and develop concepts of technical assistance."

At the January 23, 1971 BCA Board meeting, a strong consensus was expressed in favor of full support and endorsement for the continued growth and development of the Plan Performance Review function as a "comprehensive, objective and searching inquiry into all areas of Plan management and operation."

At the March 12, 1971 Special Meeting of the Board of Governors, among the policy statements adopted were the following:

> 3. Member Plans were required to have a conflict of interest policy and procedures following Board guidelines as a special obligation of membership. The Board directed the BCA Performance Review staff to implement this policy as an ongoing part of its Plan Performance Program;
>
> 4. The Board approved a slight modification of Section 4—Visitation—of the BCA By-laws;
>
> 5. Reaffirmed its support of rigorous Plan Performance Review program for management, fiscal status, systems, national accounts and ad hoc purposes —for the development of Performance Standards and technical assistance. With regard to Performance Standards, the Board saw the need to focus on "im-

proved subscriber services, including such areas as claims payment, notices of hospital admissions, ID cards and the Inter-Plan Service Bank";

8. The Board reaffirmed its support for the March 31, 1970 Statement on Diversification which included a role for Plan Performance.

At the June 9-10, 1971 Board meeting, the recommendations of the Plan Performance Committee were endorsed and the Committee authorized "to establish and approve standards of Plan Performance, including the updating and modification of such standards in the light of experience; provided, however, that the Board be kept informed on a continuing basis. . ."

At the February 5, 1972 Board meeting, the Board endorsed and approved management recommendations regarding the review and monitoring of BCA performance and the relationship to the committee now known as the Standing Committee on Operating Plan and Budget.

The foregoing indicates that the Plan Performance Committee is ongoing and is responsible for monitoring the performance of the BCA and Blue Cross Plans, and, in conformance with the 1964 Board action, was given the responsibility to identify problems for individual Plans which would affect adversely other Plans and to provide corrective assistance; to assist Plans in maintaining their approved status (now under the program as administered by BCA); review membership status with reference to special obligations of membership (again to assist Plans in maintaining compliance with the special obligations of membership). With regard to the latter, it should be pointed out that some special obligations of membership are now included in the interpretations to Approval Standards #1 and #7. In addition, the Plan Performance Committee monitors and reviews specific problems as

identified by the Board of Governors and the committee and makes recommendations for their resolution and improvement, when appropriate and necessary (e.g., diversification and conflict of interest matters).

Liaison between the two BCA divisions involved with licensure, approval and Plan performance (i.e., Legal and Corporate and Administrative Services) and between the various committees involved (i.e., the Executive Committee, the Standing Committee, the Plan Performance and Plan Approval Committee) has been maintained. In line with the practice commenced in 1964, the Senior Director, Approval and Licensure Programs, makes available immediately, a copy of the completed Plan reapproval application. In addition, (after Plan visits) he alerts Administrative Services to matters which merit consideration for Plan assistance. Conversely, the Administrative Services team (after visits) alerts the Legal and Corporate Division to matters which might affect a Plan's approval status. Both divisions cooperate in the handling of matters involving conflict of interest, and particularly diversification, for which the Executive Committee has retained prime monitoring responsibility.

LICENSE REQUIREMENTS OF GENERAL APPLICATION—
BCA LICENSE AGREEMENT

The Plan shall, as a condition to the grant and to the continuance of its licensing hereunder, comply with the following requirements:

(a) The corporate body of each Plan shall be representative of the community and hospitals served by such Plan.

(b) Trustees, board and corporation members of each Plan shall receive no compensation for services as such.

Exhibit 4A

(c) No portion of the earnings remaining after payment of the cost of operation shall inure to the benefit of any individual.

(d) Every qualified general hospital in the area served by the Plan shall have reasonable opportunity to become a contracting hospital.

(e) Subscribers shall have free choice among contracting hospitals.

(f) Service benefits, as distinguished from wholly cash indemnity benefits, and as determined in good faith by the Plan, shall be provided through contract between the Plan and its contracting hospitals.

(g) Provision shall be made for benefits in qualified noncontracting hospitals.

(h) The finances of every Plan shall be kept separate from those of any hospital.

(i) No employee of a Plan shall be paid principally by commission or on a production fee basis.

(j) The foregoing requirements shall apply except to such extent as may be prohibited by law.

Exhibit 4B

APPROVAL PROGRAM FOR BLUE CROSS PLANS

This booklet describes the official Approval Program for Blue Cross Plans. It supersedes all previously published statements.

As early as 1933, the concept of Prepayment for Hospital Care was endorsed and within several years thereafter a set of Approval Standards for Non-Profit Hospital Service Plans was adopted. The Approval Program has been in continuous operation ever since. During this period, on several occasions, the Approval Standards and their interpretations were strengthened and clarified.

The purpose of the Approval Program for Blue Cross Plans is to assure that standards of Performance are maintained to protect the interests of the public.

The interests of the public are protected by standards which require a Plan—to include representatives of the public and hospitals on its policy-making governing board; to promote enrollment; to provide benefits which substantially cover the costs of hospital services; to achieve and maintain financial stability; to pay out at least 85 per cent of subscriber income in the form of subscriber services; to report to the public concerning its operations and its programs; to operate in such a manner that none of its net earnings shall inure to the benefit of any individual, and to meet certain licensing requirements which permit the Plan to use the Blue Cross symbol and name which are registered by the Blue Cross Association.

Only those Blue Cross Plans which are approved by the Blue Cross Association have the right to use the words "Approved by the Blue Cross Association."

General Principles

1. Approval of the Blue Cross Association and the words "Approved by the Blue Cross Association" shall be

determined by a Plan's adherence to the "standards" set forth in the following section.

2. The Interest and Responsibility of contracting hospitals, that is, hospitals guaranteeing service, make it desirable that in addition to representatives of the general public, the Plan's governing board shall include representatives of such hospitals. It is also desirable that the medical profession be represented on the Plan's board.

3. All Hospitals in Each Enrollment Area that are qualified and equipped to provide the services in the Plan's subscriber certificate should have an opportunity to contract to provide these benefits. At least a majority of these hospitals should so contract. Equitable arrangements should be made for provision of benefits in non-contracting hospitals.

4. No Plan Should Be Given Original Approval whose territory does not comprise sufficient area and population to provide adequate spread of risk and efficient and economical management, with an adequate number of hospitals to assure service to subscribers.

5. Plans Should Arrange for Service Benefits to hospitals, rather than provide cash allowances for the purchase of hospital care.

Approval Standards for Blue Cross Plans Within the United States

1. Organizational Structure

A Plan's corporate and administrative structure shall be consistent with its scope and functions, and shall be governed by a board composed of representatives of the public and providers of service.

Interpretation:

A. At least one-third of the members of the Plan's governing board shall be representative of the public and at least one-third shall be representative of the contracting hospitals.

B. The interests of any officer, director or trustee of a Plan shall not be in conflict with the interests of the Plan.

2. Authority to Operate

A Plan shall operate as a voluntary, non-profit, community service organization.

Interpretation:

A. A Plan shall have defined community service objectives which it implements in its operations.

B. A Plan shall operate in conformance with its legal authority.

C. Trustees or board members of a Plan shall receive no renumeration for such service, nor shall any part of the net earnings of a Plan inure to the benefit of any individual.

3. Benefits to Members

A Plan shall provide its members with benefits which substantially cover the costs of hospital services.

Interpretation:

A. A Plan shall cover, on behalf of all member patients, an average of not less than 75 per cent of the total amount billed for usual and customary hospital services rendered on an inpatient basis in mul-

tiple bed accommodations in contracting hospitals. There shall also be some provision for outpatient coverage.

B. A Plan shall have provided as subscriber benefits, a minimum average of 85 per cent of its earned subscriber income during the three-year period immediately preceding the current approval review.

C. A Plan's benefits shall be increased to keep pace with the development of expanded services in contracting hospitals, and to work toward comprehensiveness of benefits.

4. Financial Responsibility

A Plan shall maintain a financial condition that adequately protects subscriber interests as evidenced by reports which include a full statement of all direct and contingent liabilities as presented in an independent annual audit.

A Plan's assets shall exceed its liabilities in order to qualify for approval.

Interpretation:

A Plan's reserves shall be deemed minimally adequate if they meet one of the three following criteria:

A. They are sufficient to meet hospital and operating expenses for a period of at least three months; or

B. They have been increased by the addition of at least three per cent of gross income during the preceding twelve-month period; or

C. They will be increased or not drastically reduced during the forthcoming twelve-month period, based on a projection of next year's operations.

5. Relationship With Individual Hospitals

A Plan shall have written agreements with at least 75 per cent of non-federal short-term hospitals registered by the American Hospital Association containing at least 75 per cent of these hospitals' beds in the Plan's service area, and the agreements shall include:

A definition of the responsibility of the Plan to the hospital with respect to frequency of hospital reimbursement.

A definition of the method of hospital payment.

A definition of the responsibility of the contracting hospital to the Plan with respect to servicing and guaranteeing service to members holding contracts for which the Plan assumes responsibility and the hospital's responsibility for the prudent use of its facilities and services.

A definition of the rights of the Plan and its contracting hospitals regarding the right of inspection of the records by the other party to the contract and a statement of the rights of either party to cancel or amend the contract.

Interpretation:

A Plan may adopt reasonable standards governing the acceptability of hospitals as contracting hospitals. In the event a Plan's standards of acceptability are more stringent than the American Hospital Association standards for registration, a lesser percentage than 75 per cent may be used by the Blue Cross Association to determine compliance with this standard.

6. Accounting and Statistical Records

A Plan shall maintain such accounting and statistical records as may be reasonably required by the Board of Governors of the Blue Cross Association and shall submit such reports on the form and in the manner so prescribed.

Exhibit 4B

7. Interplan Cooperation

A Plan shall participate in national programs, generally accepted by Plans.

Interpretation:

The continuing availability of hospital service benefits to large segments of the public without geographic restriction requires effective cooperation among Plans and their contracting hospitals.

8. Enrollment

A Plan's enrollment objectives shall be determined and results shall be evaluated at least annually.

Interpretation:

A. A Plan shall provide group and non-group enrollment opportunities to the people in its service area at least annually.

B. Responsibility for promotion and enrollment shall be vested in the salaried management of the Plan. An independent sales agency shall not be given responsibility for promotion and administration.

9. Public Information

A Plan shall conduct a continuing informational program to explain its functions, services, financing, and responsibilities to the public.

10. Relationship With Organized Groups of Hospitals

A Plan shall maintain close liaison with organized groups of hospitals in its area.

Exhibit 4B

Interpretation:

A. The Plan representatives and the state or local hospital association representatives shall meet at least semiannually to discuss matters of mutual interest.

B. A Plan shall participate in programs sponsored by organized groups of hospitals.

C. A Plan shall regularly exchange with organized groups of hospitals, statistical, financial or any other information of mutual interest.

11. Licensed by the Blue Cross Association

A Plan shall be a licensee in good standing under an agreement with the Blue Cross Association which attests to the Plan's compliance with the standards for such licensure and permits it to use the Blue Cross symbol and name.

Failure to Meet Approval Standards

If a Plan fails to meet the provisions of one or more of the foregoing standards, the Plan Approval Committee may recommend to the Board of Governors of the Blue Cross Association that such Plan's approval be terminated. If a Plan fails (a) to furnish such information in support of its application as may reasonably be required, or (b) to comply with the foregoing standards, all within such period as the Board of Governors may deem reasonable, the Board of Governors may terminate its approval.

If a Plan's failure to comply with one or more of these standards results in its being notified that approval is to be withdrawn, it shall have the right, upon request to the Board of Governors of the Blue Cross Association, to present evidence of the extent to which circumstances prevent compliance.

Exhibit 4B

APPROVAL REQUIREMENTS FOR ORGANIZATIONS
OPERATING NON-PROFIT BLUE CROSS PLANS
OUTSIDE THE UNITED STATES

1. The governing board shall contain representation of the public and of hospitals from the area served.

2. No member of the governing board shall receive compensation for service as such.

3. No portion of the earnings remaining after the cost of administration has been satisfied shall inure to the benefit of any individual.

4. Subscribers shall have free choice of physician and hospital.

5. The Plan shall make available to the public benefits which shall cover at least 75 per cent of that portion of hospital expense which the Plan acknowledges it is in business to prepay.

6. Provision shall be made for benefits in out-of-area cases.

7. Finances shall not be comingled with those of any hospital.

8. No employee shall receive more than half of his compensation through commissions or on a production-fee basis.

9. Reports as to fiscal condition and membership status and such other reports as may reasonably be required shall be furnished to the Blue Cross Association upon request.

10. The Plan shall be a licensee in good standing to use the Blue Cross symbol and the words "Blue Cross."

11. The foregoing requirements shall apply except as they may be prohibited by law.

Exhibit 4B

SPECIAL OBLIGATIONS OF MEMBERSHIP

Eligibility for Regular Membership in the Association (Article III, Section I) requires that "Each Blue Cross Plan . . . has been and continues to be formally approved by the Blue Cross Association . . ." Each Regular Member is obligated to pay monthly dues and marketing service charges (Article III, Section 2). Plans must also use their best efforts to cooperate and support BCA in the achievement of its obligations and purposes and to abide by the intent and spirit of the Association's By-Laws (Article III, Section 3 (g)).

Special obligations are set forth in Article III, Section 3. Originally, subparagraph (a) bound Plans to participate in the Service Benefit Bank Agreement, Transfer Agreement, the Local Benefit Agreement for National Accounts and the National Advertising Program. In order to avoid the necessity of reprinting the By-Laws at times when other obligations might be added, the Plans adopted an amendment to the By-Laws on July 14, 1971 whereby other programs and procedures as may be approved by the Board from time to time and adopted by the affirmative vote of the Regular Members entitled to ⅔ (two-thirds) of the weighted votes could be made obligations of membership. In this fashion, there was added an obligation of membership, effective October 1, 1971, requiring each Regular Member to adopt and implement a conflict of interest policy and procedure following BCA guidelines contained in memorandum dated January 15, 1971. Subsequently, in connection with the transfer of the licensure and approval programs from AHA to BCA, the Members added another special obligation of membership requiring compliance with the standards of the present "Approval Program for Blue Cross Plans" and as it may be amended from time to time on approval of the Board and the affirmative ⅔ (two-thirds) weighted vote of Member Plans.

Exhibit 4B

Over the years, in actions pursuant to the provisions of subparagraphs (b), (c), and (d), the Board of Governors has approved various benefit patterns embodied in the National Account Contract and numerous riders, the last one dealing with "abortion" benefits. In the same manner, the provision of service benefits for out-of-hospital prescription drugs was accomplished (June 23, 1967). Similarly, the Board has approved the equalization document and various amendments.

REQUIREMENTS FOR AFFILIATE MEMBERSHIP

(By-Laws Article V. Sec. 1)

1. The non-profit organization shall provide health service benefits.

2. The organization's governing board shall contain representatives of the public and the providers from the area served and no board member shall receive compensation for service as such.

3. The earnings of the organization shall not enure to the benefit of any individual.

4. The organization shall demonstrate a continuing interest in the policies of the Blue Cross Association.

5. The organization shall have made significant contributions to the field of prepaid health care.

6. The organization shall not use the registered service marks, the term "Blue Cross" and the design of a Blue Cross without the prior written permission of or written license from the Blue Cross Association.

Exhibit 6A

CO-PAY PREFERRED COMPREHENSIVE SUBSCRIPTION AGREEMENT

ARTICLE I. IN-PATIENT BENEFITS

Blue Cross will provide to each Subscriber In-Patient Benefits as follows:

Section 1. Days Available

All benefits provided under this Agreement for in-patients shall be available to each Subscriber for not more than the number of days specified below for each benefit period, based on the Subscriber's classification and length of continuous membership in Blue Cross at the time of admission. Successive admissions for purposes of this Agreement shall be considered to constitute a single benefit period if discharge from and subsequent admission to any hospital or extended care facility occur within a 90-day period, except when otherwise specified.

In computing the number of days of benefits, the day of admission, but not the day of discharge, shall be counted; except, however, if the Subscriber is admitted and discharged on the same day, it shall be counted as one day.

A. *Hospital Days Available Per Benefit Period*

(1) General Conditions—the following number of days are available for conditions other than those designated in subparagraphs A(2) through A(5) below:

Group Subscribers	*Length of Membership*	*Non-Group Subscribers*
50 days	First Year	30 days
60 days	Second Year	40 days
80 days	Third Year	50 days
100 days	Fourth Year	60 days
120 days	Fifth Year and Thereafter	70 days

(2) Pregnancy, including any disease, injury or condition arising therefrom—up to 6 days, except in cases of:

(a) Caesarian section or premature termination of pregnancy not resulting in childbirth—up to 10 days; or

(b) Ectopic pregnancy, eclampsia, post partum hemorrhage, retained secundines and such other severe complications of pregnancy as may be determined by Blue Cross—up to the number of days to which the Subscriber is then entitled under Subparagraph A(1) above.

(3) Mental or Nervous Disorders, Alcoholism and Drug Addiction or any combination thereof—up to 30 of the days to which the Subscriber is otherwise entitled as set forth in subparagraph A(1) above. Readmission within 365 days of the last discharge for any of these conditions shall be considered to be in the same benefit period.

(4) Removal of Tonsils and/or Adenoids—1 day for Subscribers under 12 years of age and 2 days for all other Subscribers.

(5) Dental Surgery, except when required because of accidental injury—1 day for Subscribers under 12 years of age and 2 days for all other Subscribers.

Days available under this Agreement shall be allowed only during uninterrupted stays in a Hospital or Extended Care Facility. Benefits shall not be provided hereunder: (1) during the absence of a Subscriber who interrupts his stay and remains absent past midnight of the day on which the interruption occurred; (2) after the discharge hour when a Subscriber has been advised by his attending physician prior to the discharge hour of the

Hospital or Extended Care Facility that further in-patient care is not required.

Section 2. Benefits in Blue Cross Member Hospitals

The following benefits when provided to the Subscriber as an in-patient in Blue Cross Member Hospitals are subject to the payment by the Subscriber of $10.00 per day toward the hospital's charges for the covered services for the first 10 days of hospitalization during each benefit period.

A. Accommodations, including bed, board, general nursing care and such other services as are covered by the hospital's regular charges for such accommodations, subject to the provisions of paragraph C of this Section 2, as follows:

(1) Semi-Private accommodations, designated as such by the hospital and containing not more than four beds, or private accommodations designated by Blue Cross as semi-private for purposes of this Agreement in hospitals having primarily single accommodations; or

(2) Private accommodations, designated as such by the hospital and containing not more than one bed, as medically necessary when the Subscribers' condition requires him to be isolated for his own health or that of other patients and as ordered by the attending physician; or

(3) A private room allowance, when the Subscriber occupies private accommodations in the absence of such medical necessity, equal to the hospital's most prevalent charge for semi-private accommodations.

Exhibit 6A

B. All additional services usually provided and billed for by hospitals (except ambulance and personal convenience items) required solely for the institution and/or the application of therapy for the condition(s) for which hospitalization is required, including but not being limited to:

(1) Special meals and dietary services; use of operating, delivery, recovery, cystoscopic, treatment and other specialty service rooms and equipment and supplies; use of intensive care, cardiac care and other such specialty service units; casts; surgical dressings and supplies; devices or appliances surgically inserted within the body; oxygen and oxygen therapy; administration of blood and blood plasma, including the processing of blood from donors but excluding the blood or blood plasma; anesthetic supplies and the use of anesthetic equipment; anesthesia when administered by a hospital employee; physical therapy when administered by a hospital employee; radiation therapy; and all drugs, medications and combinations thereof (including intravenous injections and solutions) for use while in the hospital and which are released for general use and are commercially available to hospitals; and

(2) Indemnity for the reasonable and customary expense incurred for certain medical services when incident to hospitalization, including laboratory, electrocardiographic, electroencephalographic and x-ray examinations, metabolism tests, anesthesia and physical therapy rendered by physicians to Subscribers in accordance with the regulations of the hospital in which the Subscriber is hospitalized and further in accordance with the arrangements existing at the time of such hospitalization between the hospital and

Exhibit 6A

the physician or physicians rendering such medical services, provided, however, that the indemnity for anesthesia shall not exceed $10.00 for any one admission.

(3) Transplant Services—When the Subscriber is the recipient of transplanted organs, bones, etc., benefits of this Agreement are provided for those services to the Subscriber which are directly and specifically related to the transplantation. Benefits are also provided for examinations of such transplanted organs, bones, etc. and the processing of blood provided to a Subscriber. No benefits are provided for the hospitalization of donors, or for blood, organs, bones, etc. provided by donors.

(4) Newborn Care—When pregnancy benefits are provided for the Subscriber, the newborn child of the Subscriber shall be an eligible Subscriber at birth and shall be entitled to benefits for (a) treatment of illness, injury or congenital defects, (b) incubator or isolette care, (c) treatment of prematurity or postmaturity, (d) circumcision, and (e) nursery care.

(5) Ambulant Care—When the Subscriber is admitted to a section of a hospital providing ambulatory, convalescent, or rehabilitative care, or is transferred to such section after first having been admitted for needed medical or surgical treatment to the acute section of the same or another hospital, the total number of days for which benefits would otherwise be available under this Agreement shall not exceed the average number of days of service, as determined by Blue Cross, for treatment of the particular diagnosis or condition.

C. Diagnostic Study—Benefits for services of the character referred to in paragraph B of Section 2 above are available when hospitalization in a Member Hospital is for "Diagnostic Study." Such benefits shall not include accommodations or those services covered by the hospital's regular charges for accommodations as provided in paragraph A of Section 2 above. "Diagnostic Study" means cases hospitalized principally for diagnostic or medical observation required for the diagnosis of a definite symptomatic condition of disease or injury (even though therapy directed toward the relief of symptoms may be rendered) as determined by Blue Cross.

Section 3. Benefits in Contracting Hospitals of any other Blue Cross Plan

Benefits will be provided for in-patient hospital services furnished by a contracting hospital of any other Blue Cross Plan in accordance with the agreement which Blue Cross has with the Inter-Plan Service Benefit Bank for the number of days then available under Article I, Section 1 of this Agreement, but in no case shall such benefits be less than the benefits provided hereunder in a Non-Member Hospital.

Section 4. Benefits in Non-Member Hospitals

Upon receipt of a valid bill, itemized as required by Blue Cross, for the Subscriber's hospitalization as an in-patient in a Non-Member Hospital, Blue Cross will pay to such Subscriber an allowance of up to $50.00 per day for the first day and up to $25.00 per day for each day thereafter toward the hospital's regular charges, except that:

A. In cases when a newborn child remains in the nursery after the mother has been discharged, such child

shall be entitled to an allowance of up to $10.00 per day toward the charges for nursery care.

B. In cases hospitalized in school infirmaries and hospitals directly or indirectly operated by any local or state governmental body or agency, an allowance of up to $5.00 per day toward such infirmary's or hospital's regular charges.

Section 5. Benefits in Member and Non-Member Extended Care Facilities

Benefits shall be available to the Subscriber for post-hospital cases requiring skilled nursing care for the continued treatment of an illness or injury which required not less than 3 days of hospitalization, provided that the Subscriber is admitted to an Extended Care Facility within 14 days following the termination of such hospitalization. For the purpose of determining the number of days to which the Subscriber is entitled under subparagraph A(1) of this Article I, each day in an Extended Care Facility shall be counted as one half day. The benefits provided to the Subscriber in such cases shall be as follows:

A. Member Extended Care Facilities

All services provided under Section 2 paragraph A and subparagraph B(1) of this Article I which are usually provided and billed for by the Extended Care Facility (except ambulance and personal convenience items);

B. Non-Member Extended Care Facilities

Upon receipt of a valid bill, itemized as required by Blue Cross for Subscriber's care in a Non-Member Extended Care Facility, Blue Cross will pay to such Subscriber an allowance of up to $12.00 per day toward the Non-Member Extended Care Facility's regular charges.

Exhibit 6A

ARTICLE II. OUT-PATIENT BENEFITS

Blue Cross will provide to each Subscriber Out-Patient Benefits as follows:

Section 1. Benefits in Blue Cross Member Hospitals

The following benefits when provided to the Subscriber as an out-patient of a Blue Cross Member Hospital are subject to the payment by the Subscriber of a $10.00 deductible toward the hospital's charges for such services:

A. All hospital services and/or the certain medical services incident to hospitalization provided in Article 1 Section 2B(1) and (2) required for treatment of illness or injury as limited herein:

(1) Accidental Injury—treatment rendered within 48 hours of the accident.

(2) Medical Emergency — treatment rendered within 48 hours of the onset of the emergency. "Medical Emergency" means a sudden and unexpected onset of a condition with severe symptoms requiring immediate medical care and includes heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsion or other such acute medical conditions as determined to be medical emergencies by Blue Cross.

(3) Surgical Operation—services required for out-patient surgery.

(4) Radiation Therapy—use of x-ray, radium, cobalt and other radioactive substances, provided, however, that the deductible shall be applicable only once during any period of four consecutive days.

B. Diagnostic Tests and Procedures when medically necessary for the diagnosis of a definite symptomatic con-

Exhibit 6A

dition of disease or injury—including radiation, basal metabolism, clinical laboratory and pulmonary function examinations; electrocardiograms and electroencephalograms; pathological examinations of tissue removed by resection or biopsy (excluding smear techniques); and such other diagnostic tests and procedures as may be designated by Blue Cross, provided, however, when any such tests and procedures are performed within any period of four consecutive days the Subscriber shall be responsible for only one deductible.

Section 2. Benefits in Contracting Hospitals of any Other Blue Cross Plan and Non-Member Hospitals

For accidental injury, medical emergency, surgical operation and radiation therapy as specified in paragraph A, of Section 1, of this Article II, Blue Cross will pay to the Subscriber an allowance of up to $10.00.

ARTICLE III. TERMS AND CONDITIONS

Section 1. Waiting Periods and Pregnancy Provisions

A. Pre-existing Conditions—Benefits for pre-existing conditions will be available to each Subscriber only after the expiration of 12 consecutive months following the effective date of this or any prior Blue Cross Agreement providing uninterrupted coverage for the Subscriber. "Pre-Existing Condition" means a condition, disease, illness or injury which existed or had its beginning to any degree, whether diagnosed or not, prior to the effective date of coverage. Benefits shall not be provided for any condition excluded from coverage by the terms of this Agreement, or by rider, even after the expiration of the 12 month period.

B. Removal of Tonsils or Adenoids—Benefits will be available to each Non-Group Subscriber only after the

expiration of 6 consecutive months following the effective date of this or any prior Blue Cross Agreement providing uninterrupted coverage for the Subscriber.

C. Pregnancy Provisions—Benefits for pregnancy will be allowed to an Applicant Subscriber or spouse enrolled under a family Subscription Agreement only after the expiration of 8 consecutive months following the effective date of such Agreement providing uninterrupted coverage for the Subscriber, except that such waiting period shall not apply in case of ectopic pregnancy and premature terminations of pregnancy not resulting in childbirth.

When there has been a change in the Subscriber's enrollment status, pregnancy benefits will be allowed on the basis of the coverage held at the time of conception.

Section 2. Exclusions

Benefits shall not be provided under this Agreement for:

A. Services, facilities or supplies (1) covered by programs created by the laws of the United States, any state or any political subdivision, (2) furnished in a federal institution, (3) in connection with any disease contracted or injury sustained during military service or war, declared or undeclared, or any act of war, (4) for any occupational condition, ailment, or injury arising out of and in the course of employment, (5) to the extent that the cost thereof may be recoverable by or on behalf of the Subscriber in any action at law or in compromise or settlement of any claim, against any party, other than an insurer of the Subscriber, (6) furnished without charge to the Subscriber.

B. Services, facilities or supplies (1) not ordered by the attending physician, (2) not reasonable and necessary

for the diagnosis or treatment of illness, injury or restoration of physiological functions (except that this exclusion shall not apply to pregnancy care, circumcision, procedures for the prevention or interruption of pregnancy and cosmetic procedures related to injury sustained while a Subscriber), (3) for the care of gums, teeth or the extraction of teeth other than impacted teeth unless such care consists of surgery for the treatment of diseases or injuries of the jaw or any structure contiguous to the jaw or for the treatment of fractures and/or dislocations of the jaw or any facial bone or (4) for custodial and domiciliary care, research studies, screening examinations, check-ups, rest cures, convalescent care, weight reduction, routine physical or pre-marital examinations, or diagnostic services or examinations in connection with pregnancy.

C. Fees of any physician, surgeon, private nurse or other professional persons or their board or other medical services except as set forth herein.

D. In Non-Member Hospitals and Contracting Hospitals of other Blue Cross Plans, in-patient cases principally for diagnosis, diagnostic study or medical observation (even though therapy directed toward the relief of symptoms may be rendered) when the necessary care can properly be provided on an out-patient basis as determined by Blue Cross and the condition of the Subscriber or the nature of the procedure does not necessitate that the Subscriber be admitted as an in-patient.

E. If Blue Cross should pay for any excluded services or supplies through inadvertence or error, the Subscriber shall reimburse Blue Cross for such payments.

Section 3. Assignment

This Agreement and the benefits hereunder are personal to the Subscriber and are not assignable by the

Subscriber in whole or in part to any person, hospital or other entity.

Section 4. Subrogation

In the event any hospital service or benefit is provided or any payment is made to a Subscriber under this Agreement, Blue Cross shall be subrogated and succeed to the Subscriber's rights of recovery therefor against any person or organization except against insurers on policies of insurance issued to and in the name of the Subscriber, and the Subscriber shall execute and deliver such instruments and take such other action as Blue Cross may require to secure such rights. The Subscriber shall do nothing to prejudice the rights given Blue Cross by this section.

Section 5. Payment of Benefits and Indemnity

A. The Subscriber, the Member Hospital, Member Extended Care Facility, and physician rendering services indemnified for herein may submit bills directly to Blue Cross to the extent that benefits and indemnity are payable within the terms and conditions of this Agreement:

(1) Blue Cross will compensate Member Hospitals and Member Extended Care Facilities periodically in accordance with the contracts entered into between such Member Hospitals or Member Extended Care Facilities and Blue Cross.

(2) Blue Cross will indemnify the Subscriber for the reasonable and customary expenses incurred for the certain medical services rendered when incident to hospitalization as described and limited herein, provided that if the bills for such service or services are submitted by the physician directly to the Subscriber, the Subscriber shall forward such bills directly to Blue Cross for payment. If, however, the bills for such services are included in the hospital bill of a Subscriber, payment therefor shall be made to the hospital, subject, however, to the then existing arrangements between the hospital and physician rendering such services.

B. That portion of any bill in excess of the limits of this Agreement is not the obligation of Blue Cross. It is the purpose of this Agreement to provide payment to hospitals and physicians for hospital services and the certain medical services rendered when incident to hospitalization within the limits of this Agreement, as indemnity for reasonable and customary expenses incurred by the Subscriber for such services, but no payment is to be made directly to any Subscriber for such services rendered by any Member Hospital.

Section 6. Termination

A. Modification or Termination—This Agreement may be modified or terminated at any time by the Blue Cross at its option upon: (1) non-payment of charges as required; (2) failure or refusal after 30 days' written notice to comply with rate or benefit changes applicable to this Agreement; or (3) failure or refusal of the Subscriber after 30 days' written notice to transfer to the Blue Cross Plan serving the area to which he has changed residence.

B. Termination by Incorrect Information or Misrepresentation—As a material inducement for the issuance of this Agreement, it is represented by the Applicant that all statements made and information shown in the Application are true and complete and are correctly recorded and noted in the Application. Any misrepresentation therein is material to the risk and will, at the option of the Blue Cross, subject to the provisions of subparagraph E hereof,

render this Agreement void from inception and will forfeit any charges theretofor paid to the extent of any liability incurred by Blue Cross.

C. Termination Without Claim Prejudice—When this Agreement is terminated, except for termination by incorrect information or misrepresentation, and a Subscriber is receiving in-patient benefits on the date of such termination, benefits will continue to be provided only to the date of discharge or expiration of eligible benefit days, whichever is earlier.

D. Renewability of Agreements Issued on a Non-Group Basis—When an Agreement is issued on a Non-Group basis, it shall be renewable at the option of the Applicant unless sufficient notice in writing of non-renewal is mailed to the Applicant by Blue Cross, addressed to the last address recorded with Blue Cross. "Sufficient Notice" is defined as follows: (1) during the first year of the Agreement or during the first year following any lapse and reinstatement, or re-enrollment, a period of 30 days; (2) during the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one-fourth the number of months of continuous coverage from the first annual anniversary of the date of issue or reinstatement or re-enrollment, whichever date is more recent, to the date of mailing of such notice, provided, however, that no period of required notice shall exceed 2 years and no renewal hereunder shall renew the Agreement for any period beyond the required period of notice except by written agreement of the Applicant and Blue Cross.

E. After 2 years from the date of issue of this Agreement no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Agreement, shall be used to void said Agreement, or to deny benefits for a claim incurred commencing after the expiration of such 2 year period.

ARTICLE IV. GENERAL CONDITIONS

Section 1. Reports and Records

A. The Subscriber agrees that the Applicant's Agent may make available to Blue Cross for inspection any employment and other personnel records which have a bearing upon the eligibility of the Enrolled Group or its Applicants.

B. Blue Cross has the right at any time to require to be furnished to it without cost or expense, as a condition precedent to liability for any claim for services under the provisions of this Agreement, the history of treatment of the Subscriber maintained or possessed by a hospital, doctor, or any other institutional or professional provider of medical services and supplies; and each Subscriber by accepting this Agreement, does fully authorize, empower, and direct such hospital, doctor, institution or provider to furnish Blue Cross with such complete history upon request; and in case of a dispute as to liability and such claim is placed in litigation, each Subscriber for himself and heirs and attorneys does hereby expressly waive the privileges and benefits of any and all laws and rules which are now in force or may hereafter be enacted or promulgated in regard to disqualifying any doctor, nurse, hospital official or employee or any other institutional or professional provider of medical services and supplies from testifying concerning any information obtained by him or her in a professional capacity, or which make such information or knowledge privileged; and each Subscriber hereunder does for himself, his heirs, and attorneys expressly authorize and direct such doctor, nurse, hospital

official or employee or any other institutional or professional provider of medical services and supplies to make such full disclosure in the hearing, investigation, or trial concerning the liability of Blue Cross for the payment of such claim.

Section 2. Cooperation

The Subscriber agrees to cooperate fully with Blue Cross, and to recognize and be governed by the rules and regulations of the public authorities and of the hospital which he selects concerning patients and the right of physicians to practice therein, that any notice mailed by Blue Cross to the Applicant's last address as it appears in the records of Blue Cross, or in the case of a Group Subscriber any notices given to the Applicant's Agent shall be deemed to have been received by the Applicant, and that he will submit promptly to Blue Cross all forms requested.

Section 3. Termination of Member Hospital or Member Extended Care Facility Contracts

The contract between Blue Cross and a Member Hospital or a Member Extended Care Facility may be terminated, without notice to the Subscriber, in accordance with the provisions thereof, provided however, in the event of such termination, the Member Hospital or the Member Extended Care Facility shall continue to render services and facilities to such Subscribers as may be in-patients at the time of such termination or who are admitted during the 90 day period following the date of such termination.

Section 4. Determination of Service

For purposes of this Agreement, Blue Cross determination of the benefit provisions applicable for the services rendered a Subscriber hereunder, shall be conclusive.

Section 5. Selection of Physician

This Agreement does not confer upon any Member Hospital or Member Extended Care Facility the right to select any physician for the Subscriber. The Subscriber shall be at liberty to select his physician provided only that such physician shall be a member of the medical staff of, or acceptable to, the hospital or the extended care facility to which the Subscriber is admitted, and nothing contained in this Agreement shall interfere with the relationship between the Subscriber and such physician selected by the Subscriber, nor be construed to interfere with the arrangements now existing or which may hereafter exist between physicians and Member Hospitals or Member Extended Care Facilities and both physicians and Member Hospitals and Member Extended Care Facilities shall be at liberty to adjust their arrangements as they may agree.

Section 6. Epidemic and Emergency Conditions

In case of war, public disaster, public emergency, general epidemic, or any other conditions that prevent all of the Member Hospitals from providing hospitalization to Subscribers, Blue Cross shall credit to the Applicants not then receiving and unable to receive hospitalization a pro-rata return of unearned subscription charges for such period of time as Member Hospitals cannot furnish hospitalization, or upon demand shall pay such pro-rata return of unearned subscription charges in cash, which credit or payment shall be in full discharge to Blue Cross of liability hereunder. The amount of credits or cash refunds hereunder shall be subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania.

Section 7. Effective Date and Term

This Agreement shall be effective from the date of its issuance, as that date appears on the records of Blue Cross, for a term of one (1) month and from month to month thereafter upon payment and acceptance by Blue Cross of the charges due and upon compliance with the terms and provisions of this Agreement or any renewal thereof, provided that in all cases where this Agreement is issued to an Applicant with whom Blue Cross has previously entered into a Subscription Agreement which is still in effect this Agreement shall, as of the date of its issuance, supersede the previous Subscription Agreement and the Application for the previous Subscription Agreement shall be recognized as and shall become the Application for this Agreement.

Section 8. Contract

This Agreement, together with any amendments or endorsements issued by Blue Cross, shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change this Agreement in any manner or degree. No action at law or in equity shall be maintainable against Blue Cross for any claim unless brought within two years from the date of the beginning of the services involved. In the event the Subscriber becomes a party to more than one Agreement with Blue Cross providing for the benefits covered by this Agreement, only the first of such Agreements shall be valid and all subsequent Agreements shall be void and without effect.

ARTICLE V. CHANGE IN STATUS AND CHARGES

Section 1. Change of Employment

If the Applicant leaves the employ of a concern where he is a member of an Enrolled Group and is re-

employed by another concern having an Enrolled Group, he shall transfer to such Enrolled Group and remit through such Enrolled Group, but if he is retired, unemployed or employed by another concern having no Enrolled Group, the Applicant shall no longer be deemed to be a member of an Enrolled Group and his charges shall be payable directly to Blue Cross at Non-Group rates and he shall be entitled to the benefits then afforded Non-Group Subscribers.

Section 2. Death of Applicant Subscriber

In the event of the death of the Applicant Subscriber, this Agreement shall terminate at the end of the current monthly term. The surviving Subscribers hereunder shall, however, be entitled to Blue Cross coverage by applying, within 60 days of such termination, for a Subscription Agreement of the type for which they are then qualified at the rates then in effect.

Section 3. Marriage of Child or Attainment of 19th Birthday

Upon marriage or attainment of 19 years of age by any child of the Applicant Subscriber, coverage of such child shall terminate at the end of the Current Agreement Year. Such child shall, however, be entitled to a Subscription Agreement of the type for which he is then qualified by applying therefor within 60 days of such termination.

Section 4. Continuation of Incapacitated Child

In the event that an unmarried child is incapable of self support because of mental or physical incapacity and is dependent on the Applicant Subscriber for over half of his support, the Applicant may apply to Blue Cross

to continue the coverage of such child under this Agreement upon such terms and conditions as Blue Cross may determine provided, however, that the coverage of the dependent child thereunder shall terminate upon marriage of such child.

Section 5. Change of Non-Group Applicant's Residence

If a Non-Group Applicant changes his residence to an area served by another Blue Cross Plan, such Applicant shall apply to the Blue Cross Plan serving that area for the issuance of an agreement of the type for which he shall then be qualified. If such Applicant fails to apply for such an agreement within 60 days, or upon the issuance of such an agreement, this Agreement shall terminate.

Section 6. Discontinuance of an Enrolled Group

If the Applicant's Agent discontinues the remittance of charges for the Enrolled Group, or if the requirements for acceptance by Blue Cross of Enrolled Groups are not maintained, said Enrolled Group shall be deemed to have been discontinued and this Agreement shall terminate. Such Applicant shall be entitled to apply to Blue Cross for the issuance of an Agreement of the type for which he shall then be qualified, which Agreement shall become effective if and when such application is accepted by Blue Cross.

Section 7. Other Changes in Status

The addition or removal of a child or spouse (married applicants must enroll spouse unless applicant is a member of a Blue Cross Group where employer pays part or all of the charges, or is covered by Medicare) and changes between Individual and Family Agreements and changes from Non-Group to Group Classification and enrollment under another type of Agreement issued by Blue Cross shall be made upon such terms and conditions as Blue Cross may determine. Applications for such changes or enrollment shall be filed on the forms of Blue Cross and shall become effective and a part of this Agreement upon acceptance by Blue Cross.

Section 8. Charges

A. The charges for this Agreement shall be based upon the administrative requirements of Blue Cross, the cost of hospital service, extended care facility service and the indemnity for the certain medical services rendered when incident to hospitalization and shall be payable in advance according to the mode of payment agreed upon.

B. In the event the Applicant Subscriber is included in a category of Subscribers which has been approved by the Insurance Department of the Commonwealth of Pennsylvania for Merit Rating, this Agreement is subject to Merit Rating in accordance with the Formula currently filed with and approved by the Insurance Department and the charges for this Agreement may be modified periodically as a result of the application of said Formula. In the event of such modification of the charges, the Applicant Subscriber shall be notified, it being agreed that notice to the Applicant's Agent is notice to the Applicant and that payment of the new charge, resulting from the application of the Merit Rating Formula, shall be considered receipt of notice and acceptance of the modification in charge. Upon receipt of such payment, Blue Cross will duly record the Applicant's acceptance of the Modification. In the absence of such payment, this Agreement shall terminate 30 days after the new charge became due and payable.

C. In the event the Applicant Subscriber is included in a category of Subscribers which has not been approved

by the Insurance Department of the Commonwealth of Pennsylvania for Merit Rating, the charges for this Agreement shall be in accordance with the Schedule of Charges currently filed with and approved by the Insurance Department. The Board of Directors of Blue Cross, subject to the approval of the Insurance Department, may change the amount of charges for this Agreement but such change shall not become effective until the expiration of the period covered by the Applicant's current payment at the time of such change. In the event of such change, the Applicant Subscriber shall be notified, it being agreed that notice to the Applicant's Agent is notice to the Applicant, and that payment of the new charge shall be considered receipt of notice and acceptance of the change in charge. Upon receipt of such payment Blue Cross will duly record the Applicant's acceptance of the change. In the absence of such payment, this Agreement shall terminate 30 days after the new charge became due and payable.

Section 9. Default in Payment of Charges and Reinstatement

If the Applicant fails to pay to Blue Cross the charges for this Agreement within 30 days after the same became due, this Agreement shall automatically terminate at the end of the period for which payment has been made. Blue Cross may, thereafter, at its option, accept payment of the charges due and upon acceptance shall reinstate this Agreement effective immediately as to benefits provided herein for injury occurring, thereafter, and for such illness as may be first manifested more than 10 days after the date of such acceptance.

ARTICLE VI. DEFINITIONS

The following definitions shall apply to this Agreement except where the context clearly indicates otherwise:

Section 1. Admission: The term "Admission" shall mean the actual entry into a hospital or extended care facility of a Subscriber who is to receive in-patient services while lodged in the hospital or extended care facility and shall continue until such time as the Subscriber is actually discharged from such institution.

Section 2. Agreement and Subscription Agreement: The terms "Agreement" and "Subscription Agreement" shall mean this contract between the Applicant and Blue Cross.

Section 3. Agreement Year: The term "Agreement Year" shall mean the 12-month period beginning with the effective date of this Agreement and each subsequent 12-month period beginning with the anniversary date of such effective date.

Section 4. Applicant and Applicant Subscriber: the terms "Applicant" and "Applicant Subscriber" shall mean the individual who applies for and with whom Blue Cross has entered into this Agreement.

Section 5 Applicant's Agent: The term "Applicant's Agent" shall mean any individual, association, corporation or other entity which, as representative of an Enrolled Group of Applicants and as Agent for the Applicant is acceptable to Blue Cross and has agreed to pay the charges payable under this Agreement to Blue Cross and to receive any information from Blue Cross on behalf of the Applicant.

Section 6. Application and Application Card: The terms "Application" and "Application Card" shall mean the written request of the Applicant for a Subscription Agreement, set forth on the approved Blue Cross printed form for this purpose, whether such written request was made for this Agreement or for a previous Agreement

between the Applicant and Blue Cross which has been superseded by this Agreement.

Section 7. Blue Cross: The term "Blue Cross" shall mean Blue Cross of Greater Philadelphia.

Section 8. Child: The term "Child" shall include the following when living in the household of the Applicant in a normal parent-child relationship: the Applicant's natural son or daughter, or legally adopted child (including a foster child pending formal adoption), or stepchild.

Section 9. Eligible Dependents: The term "Eligible Dependents" shall mean the spouse and unmarried children of the Applicant (as provided in Article V Section 3) provided that the charges paid for this Agreement cover such dependents.

Section 10. Extended Care Facility: The term "Extended Care Facility" shall mean an institution or a distinct part of an institution licensed or approved as such under state or local law, primarily engaged in providing skilled nursing care and related services for patients who require such medical or rehabilitative services which is approved by the Joint Commission on Accreditation of Hospitals or by Blue Cross.

Section 11. Group and Enrolled Group: The term "Group" and "Enrolled Group" shall mean a group of Subscribers which has been accepted by Blue Cross, consisting of all those actively employed Applicants whose charges are remitted by the Applicant's Agent, together with all the Subscribers listed on the application cards or amendments thereof of such Applicants, which Subscribers have been accepted by Blue Cross.

Section 12. Hospital: The term "Hospital" shall mean a hospital licensed or approved for operations as such by

the applicable State Agency in which it is located and approved by the Joint Commission on Accreditation of Hospitals, by the American Osteopathic Hospital Association or by Blue Cross.

Section 13. Inter-Plan Hospital: The term "Inter-Plan Hospital" shall mean a hospital which has a contract with a hospital service Blue Cross Plan, other than Blue Cross of Greater Philadelphia, which is an eligible participant of the Inter-Plan Service Benefit Bank.

Section 14. Member Hospital: The term "Member Hospital" shall mean a hospital with which Blue Cross has a contract for the rendering of benefits under this Agreement.

Section 15. Member Extended Care Facility: The term "Member Extended Care Facility" shall mean an Extended Care Facility with which Blue Cross has a contract for the rendering of benefits under this Agreement.

Section 16. Non-Member Hospital: The term "Non-Member Hospital" shall mean a school infirmary or a hospital other than a Member Hospital or an Inter-Plan Hospital which is approved by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Hospital Association or by Blue Cross.

Section 17. Non-Member Extended Care Facility: The term "Non-Member Extended Care Facility" shall mean an Extended Care Facility other than a Member Extended Care Facility.

Section 18. Subscriber: The term "Subscriber" shall mean the Applicant and all Eligible Dependents. All Subscribers whose charges are remitted to Blue Cross at group rates shall be classified as Group Subscribers and all other Subscribers shall be classified as Non-Group Subscribers.

Exhibit 6B

DIAGNOSTIC X-RAY, DIAGNOSTIC MEDICAL, DIAGNOSTIC PATHOLOGY, AND ANESTHETIC AGREEMENT

THIS AGREEMENT, made between the Applicant named in the Application therefor and PENNSYLVANIA BLUE SHIELD, a Pennsylvania non-profit corporation, hereinafter called Blue Shield.

ENTITLES the Applicant, in consideration of payment in advance of the appropriate subscription rates, to have Blue Shield pay for those Services hereinafter set forth, performed for the Applicant and all Eligible Dependents, all subject to the definitions, terms, conditions, and provisions set forth in this Agreement.

ARTICLE I. DEFINITIONS

Applicant shall mean the individual who applies for this Agreement.

Applicant's Annual Income shall mean the total income (for the twelve-month period immediately preceding the date of the performance of each Service hereunder) of the Applicant, his spouse, his eligible dependents, and any other persons whose chief support is furnished by the Applicant or the Applicant's spouse.

Application shall mean the written request of an Applicant for an Agreement, set forth on the form furnished by Blue Shield, together with any amendments or modifications thereof, whether such written request was made for this Agreement or for a previous Blue Shield Agreement which has been superseded by this Agreement.

Conversion Subscriber shall mean a Subscriber who leaves a Blue Shield Group and continues his membership

Exhibit 6B

in Blue Shield by remitting the subscription rate directly to Blue Shield at the non-group rate.

Effective Date shall mean the date that this Agreement is effective, as shown on the records of Blue Shield.

Eligible Dependents shall mean the spouse of the Applicant and all unmarried dependent children until they attain 19 years of age, provided that the subscription rate paid covers such dependents; and unmarried dependent children 19 years of age or older who, in the judgment of Blue Shield, are incapable of self-support by reason of physical or mental disability, provided that the rate paid covers such dependents, and that such dependents must be continuously supported by the Applicant.

Plan A shall mean that Plan under which the Subscriber is entitled to have Blue Shield pay for Services in accordance with Fee Schedule A.

Plan B shall mean that Plan under which the Subscriber is entitled to have Blue Shield pay for services in accordance with Fee Schedule B.

Fee Schedule (designated as either Fee Schedule A or Fee Schedule B) shall mean the list of procedures and amounts indicating the maximum Blue Shield payments for the respective Services performed for Subscribers, as filed with and approved by the Insurance Commissioner of the Commonwealth of Pennsylvania from time to time.

Group Subscriber shall mean a Subscriber whose subscription rate is collected and remitted to Blue Shield by a Remitting Agent along with the rates of other Subscribers, all of whom have been accepted as a Group by Blue Shield.

Identification Card shall mean the currently effective card which is issued to an Applicant evidencing the issuance of this Agreement.

Non-Group Subscriber shall mean a Subscriber who is not a Group or Conversion Subscriber.

Participating Doctor shall mean a doctor with whom Blue Shield has a contract with respect to Services performed for Subscribers.

Remitting Agent shall mean any individual, firm, association or corporation which, as representative of an enrolled group of Subscribers and as their agent, is acceptable to Blue Shield and has agreed to collect or pay the subscription rates respectively payable by such Subscribers and to remit the same to Blue Shield. Such Remitting Agent is not an agent of Blue Shield.

Services shall mean the Services set forth hereinafter when medically necessary and when performed by a doctor of medicine, osteopathy, dental surgery or podiatry within the scope of his license.

Subscriber shall mean collectively the Applicant and all Eligible Dependents.

ARTICLE II. SERVICES

A. Diagnostic X-Ray Services

The Subscriber, subject to the provisions and conditions hereinafter set forth, shall be entitled to diagnostic X-ray examinations, made either in or out of the hospital, which are required in the diagnosis of any condition due to disease or injury which are:

1 Ordered by a doctor of medicine, osteopathy, dental surgery or podiatry who is engaged in general or special practice other than radiology and when so ordered are made by a doctor of medicine or osteopathy, other than the doctor ordering such X-ray examinations, who limits his practice to radiology; *or*

2 Made by a doctor of medicine or osteopathy qualified to undertake radiological examinations within the confines of a single specialty; *or*

3 Made by a doctor of medicine, osteopathy, dental surgery or podiatry in emergencies or emergency traumatic cases.

The additional provisions and conditions under which the Subscriber shall be entitled to the diagnostic X-ray Services heretofore set forth are:

1 The Subscriber shall be liable to pay the first $5 (hereinafter called the "deductible") for any such examination or series of examinations within any period of four (4) consecutive days;

2 Blue Shield shall pay for such examinations the applicable fee listed in the Fee Schedule (or the doctor's charge, whichever is lower), less the deductible; provided, however, that in the case of Non-Group Subscribers, such diagnostic X-ray Services will not be available unless and until this Agreement has been in force twelve (12) complete consecutive months, for the diagnosis of any condition, disease or injury which exists at or before the Effective Date of this Agreement.

B. Diagnostic Medical Services

The Subscriber, subject to the provisions and conditions hereinafter set forth, shall be entitled to the following types of diagnostic medical examinations:

a. Cardiographs

b. Basal Metabolism

c. Electroencephalograms

d. Radioisotopic studies

made either in or out of the hospital, which are required in the diagnosis of any condition due to disease or injury; provided, however, that such diagnostic medical examinations shall be made or ordered by a doctor of medicine or osteopathy.

The additional provisions and conditions under which the Subscriber shall be entitled to the diagnostic medical Services heretofore set forth are:

1 The Subscriber shall be liable to pay the first $5 (hereinafter called the "deductibe") for any such examinations or series of examinations within any period of four (4) consecutive days;

2 Blue Shield shall pay for such examinations the applicable fee listed in the Fee Schedule (or the doctor's charge, whichever is lower), less the deductible; provided, however, that in the case of Non-Group Subscribers, such diagnostic medical Services will not be available unless and until this Agreement has been in force for twelve (12) complete consecutive months, for the diagnosis of any condition, disease or injury which exists at or before the Effective Date of this Agreement.

C. Diagnostic Pathological Services

The Subscriber, subject to the provisions and conditions hereinafter set forth, shall be entitled to diagnostic pathological examinations, made either in or out of the hospital, which are required in the diagnosis of any condition due to disease or injury; provided, however, that such diagnostic pathological examinations shall be made

or ordered by a doctor of medicine, osteopathy, dental surgery or podiatry.

The additional provisions and conditions under which the Subscriber shall be entitled to the diagnostic pathological Services heretofore set forth are:

1 The Subscriber shall be liable to pay the first $5 (hereinafter called the "deductible") for any such examinations or series of examinations performed within a period of four (4) consecutive days;

2 Blue Shield shall pay for such examinations the applicable fee listed in the Fee Schedule (or the doctor's charge, whichever is lower), less the deductible; provided, however, that in the case of Non-Group Subscribers, such diagnostic pathological Services will not be available unless and until this Agreement has been in force for twelve (12) complete consecutive months, for the diagnosis of any condition, disease or injury which exists at or before the Effective Date of this Agreement.

D. Anesthetic Services

The Subscriber shall be entitled to anesthetic Services in or out of the hospital, consisting of the administration of spinal anesthetic, or the administration of rectal anesthetic, or the administration of a drug or other anesthetic agent by injection or inhalation, (but excluding the administration of local infiltration anesthetic), the purpose and effect of which administration are the obtaining of muscular relaxation, loss of sensation, and loss of consciousness, performed by (or under the direct personal supervision of) a doctor of medicine, osteopathy or dental surgery other than the operating surgeon or his assistant in connection with the performance of:

1 Surgical services by a doctor of medicine, osteopathy or podiatry; provided, however, that in the case of Non-Group Subscribers, anesthetic Services will not be available in connection with surgical services for: (1) any condition, disease or injury which exists at or before the Effective Date of this Agreement, unless and until this Agreement has been in force for twelve (12) complete consecutive months; and (2) a tonsillectomy and/or adenoidectomy, unless and until this Agreement has been in force for six (6) complete consecutive months.

2 Obstetrical delivery services by a doctor of medicine or osteopathy; provided, however, that anesthetic Services will not be available in connection with obstetrical delivery services, unless and until this Agreement has been in force for eight (8) complete consecutive months.

3 Oral surgical services consisting of cutting procedures for the treatment of diseases and injuries of the jaw, or any structure contiguous to the jaw, the treatment of fractures and dislocations of the jaw or any facial bone, and the extraction of impacted teeth when partially or totally covered by bone; provided, however, that in the case of Non-Group Subscribers, anesthetic Services will not be available in connection with oral surgical services for any condition, disease or injury which exists at or before the Effective Date of this Agreement, unless and until this Agreement has been in force for twelve (12) complete consecutive months.

The amount payable by Blue Shield for the aforesaid anesthetic Services shall be computed in accordance with the Plan B Fee Schedule, less any amount payable under

a Hospital Service Contract; provided, however, that in the case of Subscribers enrolled with Blue Shield under a Plan A Agreement the amount payable shall be computed in accordance with the Plan A Fee Schedule, less any amount payable under a Hospital Service Contract. If anesthetic Services are performed in connection with more than one operation or procedure, the amount payable shall be based on the total fee payable for all such operations or procedures as set forth in the applicable Fee Schedule. In no event shall the amount payable be greater than the doctor's (anesthesiologist's) charge, less any amount payable under a Hospital Service Contract.

ARTICLE III. FURTHER PROVISIONS UNDER WHICH SERVICES WILL BE PROVIDED

A. Determination of Type of Service

Determination by Blue Shield as to whether the type of Service performed for a Subscriber is Diagnostic X-ray, Diagnostic Medical, Diagnostic Pathological, or Anesthetic, shall be conclusive.

B. General Limitations

The services performed for Subscribers shall not include the following:

1 Services for any occupational condition, ailment or injury arising out of and in the course of covered employment under Workmen's Compensation or Occupational Disease Laws, Federal Employers' Liability Acts or other similar State or Federal legislation; or provided by the United States Veterans Administration; or provided without cost to the Subscriber by any Federal, State, County or Municipal

hospital, agency, or instrumentality; or the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim.

2 Services or supplies provided by any governmental body or instrumentality, whether federal, state or local, pursuant to any program under which any periodic payment of premium, rate, enrollment fee or other similar charge is made by or for the Subscriber.

3 Services not incident or necessary to diagnosis or treatment of a sickness or injury.

4 Diagnostic X-ray, diagnostic medical and diagnostic pathological Services in connection with pregnancy, research studies, premarital examinations, fluoroscopy without films, routine procedures provided on admission to a hospital, or any examination not incident to or necessary to diagnosis of a sickness or injury.

5 Services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth; and including but not limited to the following: apicoectomy, root canal treatments, soft tissue impactations, gingivectomy and alveolectomy.

6 Services in connection with plastic operations for cosmetic or beautifying purposes, except those which are performed to correct a condition resulting from an accident occurring on or after the Effective Date of this Agreement.

7 Services in connection with the treatment of corns, bunions (except capsular or bone surgery therefor), callouses, nails of the feet (except surgery for ingrown nails), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet (except when surgery is performed).

8 Services for which the fees or charges are claimed by hospitals, laboratories, or other institutions; or when the services are covered to any extent under a Hospital Service Contract.

9 Services in a hospital performed by a doctor who in any case is compensated by the hospital for similar Services when performed for patients.

10 Services performed by doctors of medicine, osteopathy, dental surgery or podiatry who do not themselves bill patients for such Services.

C. Payment for Services of Participating Doctors

1 With respect to diagnostic X-ray, diagnostic medical, and diagnostic pathological Services, payment shall be made in accordance with Blue Shield's Plan B Fee Schedule as follows:

a. Participating Doctors who perform such Services for Subscribers enrolled hereunder shall make no charge, other than the deductible, if the Applicant is single and without any person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $4,000; or if the Applicant is married or has any other person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $6,000.

b. If the Subscriber does not qualify for Services to be performed without charges, as hereinbefore set forth, Blue Shield will pay the Participating Doctor for the Services in accordance with the Plan B Fee Schedule, or the amount charged by the doctor, whichever is lower, less the deductible. If the doctor charges in such cases an amount in excess of the amount fixed in the Plan B Fee Schedule, it shall be the personal responsibility of the Subscriber to pay such difference to the doctor.

c. Payment by Blue Shield of the amount charged or the amount fixed in the Plan B Fee Schedule, whichever is lower, less the deductible, for any such Service, shall constitute full discharge of Blue Shield's liability hereunder with respect to such Service.

2 With respect to anesthetic Services, payment shall be made in accordance with Blue Shield's Plan A or B Fee Schedule as follows:

a. Participating Doctors who perform such Services for Subscribers with respect to whom the Plan A Fee Schedule is applicable as provided in paragraph D of Article II shall make no charge for such Services if the Applicant is single and without any person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $2,500; or if the Applicant is married or has any other person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $4,000.

b. Participating Doctors who perform such Services for Subscribers with respect to whom the Plan B

Fee Schedule is applicable as provided in paragraph D of Article II shall make no charge for such Services if the Applicant is single and without any person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $4,000; or if the Applicant is married or has any other person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $6,000.

c. If the Subscriber does not qualify for Services to be furnished without charge as hereinbefore set forth, Blue Shield will pay the Participating Doctor for the Services in accordance with the applicable Fee Schedule (A or B) or the amount charged by the doctor, whichever is lower, less in either case any amount payable under a Hospital Service Contract. If the doctor charges in such cases an amount in excess of the amount fixed in the applicable Fee Schedule, it shall be the personal responsibility of the Subscriber to pay such difference to the doctor.

d. Payment by Blue Shield of the amount charged or the amount fixed in the applicable Fee Schedule, whichever is lower, less any amount payable under a Hospital Service Contract for any anesthetic Service, shall constitute full discharge of Blue Shield's liability hereunder with respect to such Service.

D. Payment for Services of Non-Participating Doctors

If any Service covered by this Agreement is performed for a Subscriber in an emergency by a doctor of medicine, osteopathy, dental surgery or podiatry who is not a Participating Doctor, Blue Shield will pay the

Exhibit 6B

amount charged or the amount fixed by this Agreement and the applicable Fee Schedule, whichever is lower, which payment shall constitute full discharge of Blue Shield's liability hereunder with respect to such Service.

E. Identification

The Applicant's Identification Card must be presented to the doctor when the Service is requested.

F. Settlement of Disputes

Any dispute between a Participating Doctor and a Subscriber with respect to the Applicant's Annual Income shall be submitted to and determined by Blue Shield and such determination by Blue Shield shall be conclusive.

G. Information and Records

The Subscriber agrees that any doctor, practitioner, nurse, or any hospital or similar institution may furnish and is hereby autho ed to furnish to Blue Shield, at any time upon its request, any and all information and records or copies of records relating to any examination, diagnosis, treatment or service performed for the Subscriber and to give testimony with respect thereto.

H. Contest

No action at law or in equity may be commenced by any Subscriber with respect to any Services performed for such Subscriber under this Agreement until thirty (30) days after Blue Shield shall have received a report of the Services involved completed on the form furnished by Blue Shield and signed by the doctor performing the Services, nor shall any such action be brought at all later than two (2) years after the performance of the Services involved.

Exhibit 6B

I. Assignment

Any rights of a Subscriber to receive Services or payments hereunder are personal to the Subscriber and may not be assigned.

J. Duplicate Blue Shield Coverage

In the event any Services to which a Subscriber is entitled under this Agreement are also covered under another Blue Shield Agreement, Blue Shield may elect to treat either one of such Blue Shield Agreements void and without effect, beginning with the date the second of such Agreements became effective.

K. Subrogation

In the event any Service is provided or any payment is made to a Subscriber under this Agreement, Blue Shield shall be subrogated and succeed to the Subscriber's rights of recovery therefor against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in the name of the Subscriber. The Subscriber shall execute and deliver such instruments and take such other action as Blue Shield may require to secure such rights. The Subscriber shall do nothing to prejudice the rights given Blue Shield by this paragraph without its consent.

L. Statutory Limitation of Blue Shield Liability

Blue Shield shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice, on the part of any officer or employee or on the part of any doctor of medicine, doctor of ostepathy, doctor of dental surgery or doctor of podiatry in the course of performing Services for Subscribers.

ARTICLE IV. SUBSCRIPTION RATES

The Applicant agrees to pay to Blue Shield, in advance as billed, the applicable subscription rate set forth in the Schedule of Rates filed with and approved by the Insurance Commissioner of the Commonwealth of Pennsylvania.

Blue Shield, subject to the approval of the Insurance Commissioner of the Commonwealth of Pennsylvania, may change the subscription rates for this Agreement, but such change shall only be effective upon thirty (30) days' notice to the Applicant or to the Remitting Agent. Payment by the Applicant of the new rate shall be deemed receipt of notice and acceptance of the change in rate. If the Applicant does not pay the new rate when it becomes effective, this Agreement shall terminate as of the end of the period covered by the subscription rate payment made by the Applicant immediately prior to the receipt of notice of the change in rate.

ARTICLE V. CONTRACT AND DURATION THEREOF

A. Contract

This Agreement and the Application therefor, together with any amendments thereto, the applicable Fee Schedule, and the appropriate subscription rate shall constitute the entire contract between the parties. No agent or employee of Blue Shield is authorized to vary, add to, or change this contract in any manner or degree, except as specifically provided herein.

B. Term and Renewal

Subject to such amendments to this Agreement as may be approved from time to time by the Insurance

Commissioner of the Commonwealth of Pennsylvania, this Agreement shall remain in effect from month to month unless notice of election to terminate it is given by the Applicant to Blue Shield or by Blue Shield to the Applicant, not less than thirty (30) days prior to the date of termination. Failure to pay the applicable subscription rate when due shall automatically terminate this Agreement and all benefits hereunder.

In the event the Subscriber becomes enrolled under the Federal Supplementary Medical Insurance Program for the Aged, Act of Congress, Public Law 89-97, Title XVIII, Part B ("Medicare Part B"), or any other governmental program whether federal, state, or local, Blue Shield reserves the right to give notice of election to terminate this Agreement but not less than thirty (30) days prior to the date of termination; provided, however, that the Subscriber shall have the right at the time of such termination to convert to such programs as Blue Shield may then have available to supplement such governmental programs.

ARTICLE VI. CONTINUANCE OF MEMBERSHIP

A. Transfer

If the Applicant leaves the employ of a concern having a Blue Shield Group and is reemployed by another concern having a Blue Shield Group entitled to similar Services, he shall transfer to such Blue Shield Group and remit his subscription rate through such Group's Remitting Agent.

B. Conversion

If the Applicant leaves the employ of a concern having a Blue Shield Group and is not employed, or is employed by another concern having no Blue Shield

Exhibit 6B

Group or having no health benefit plan with any other organization, the Applicant may elect to become a Conversion Subscriber.

C. TERMINATION OF GROUP

If the Applicant's Remitting Agent ceases to remit the subscription rate (other than for the reason stated hereinafter) for the Blue Shield Group for which it acts, such Group shall be deemed discontinued and the Applicant may elect to become a Conversion Subscriber. If the Applicant's Blue Shield Group participates in or secures coverage under a health benefit plan or arrangement made available by some other organization, such action shall automatically terminate this Agreement, and there shall be no right of conversion hereunder.

ARTICLE VII. NOTICE

Any notice mailed by Blue Shield to a Subscriber or to the Subscriber's Remitting Agent at the last address as shown on the records of Blue Shield shall be deemed notice to the Subscriber for the purpose of this Agreement.

Exhibit 14

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Harrisburg

The Commissioner

March 24, 1971

The Associated Hospital Service
of Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Re: Uniform Cost Contract 1967—
Revised Effective July 1, 1970

Gentlemen:

I hereby direct you to cancel all the above referred to contracts with member hospitals subject to immediate renegotiation. Amendment of these contracts within the guidelines indicated during the course of our recent hearings is to be completed prior to July 1, 1971.

You have already received a number of suggestions for the contract and you may except additional comments in the near future.

This confirms my earlier written and oral instructions.

Sincerely,

/s/ HERBERT S. DENENBERG
HERBERT S. DENENBERG

HSD:fw

Exhibit 15

GUIDELINES

1. *Duplicative and Underutilized Facilities and Services.*

It is generally agreed that there is a good deal of duplication and underutilized hospital facilities and services. Perhaps the classic example is open-heart surgery and certain types of hospital services, such as the pediatric and maternity division.

Some agency might be selected to determine which duplicative and underutilized facilities and services should be phased out and which new ones should be authorized for the future.

The Blue Cross-hospital contract negotiations should consider new approaches to the elimination of unnecessary and duplicative services.

2. *Elimination of Unsafe and Otherwise Substandard Beds.*

Blue Cross subscribers should not be called on to pay for the use of unsafe and unsuitable hospital beds. Blue Cross and the hospitals should consider not reimbursing for such beds and closing them down altogether. Certainly, in areas where there are excessive beds, there is no reason for not closing down beds and hospitals which are unsafe or otherwise unsuitable.

Some hospitals can be closed altogether. Other hospitals can close some units, and perhaps still maintain adequate beds by use of pre-admission testing, the seven-day work-week, and similar measures.

3. *Financing of Residents and Interns.*

The costs of residents and interns, as part of hospitals' reimbursable costs, have been rapidly escalating, and is a substantial cost factor. In medical school hospitals, this cost may run as high as $10. per day per patient and the end is not in sight.

Exhibit 15

One possibility is the transfer of this cost to the physicians themselves. Other possibilities should be explored. For example, some maximum limit for the costs of residents and interns might be established.

4. *Limitation on the Number of Employees.*

Many hospitals have increased their employee force, sometimes without any apparent increase in patient care. There is now no effective limitation on unnecessary personnel increases.

The contract should consider provisions to control increases in personnel and perhaps even rollbacks on present personnel. An agency might be selected to authorize any additional employees, including salaried physicians.

5. *Depreciation.*

Reimbursing for depreciation, as a hospital cost, has been a hotly debated question for some time. Some believe depreciation as a cost should be sharply limited or eliminated altogether. The cost implications of depreciations are substantial. The depreciation expenses at some hospitals may run $10. per day or more, and the aggregate bill for depreciation is sharply rising. It is clearly time to carefully reconsider this issue.

6. *Prospective Rating.*

There are inherent weaknesses in reimbursing on the basis of open-ended costs.

Consideration should be given to some form of prospective rating so a hospital's expenditures for a given period can be fixed in advance.

Consideration might also be given to determining a specified aggregate annual amount of money payable by

all Blue Cross subscribers, which would then be appropriately distributed to all participating facilities for all services to be rendered.

7. *Budgetary Review.*

Each hospital should operate on a budget, and these budgets should be submitted to Blue Cross in advance for prior review.

Hospitals, whose costs are out-of-line when compared to similar institutions, could then be so advised and appropriate corrective measures taken.

Consideration should be given to all methods of advance budgetary review and authorization.

8. *Adoption of Cost-Saving Devices.*

Hospitals have not taken advantage of proven cost-saving devices, such as pre-admission testing and graded care.

The contract should require such economies rather than merely offer incentives for their implementation. Consideration should be given to all such economies that can be built into the contract.

9. *Ancillary Services Provided by Physicians.*

The compensation arrangement for the services of ancillary specialists—anesthesiologists, pathologists and radiologists—often produce fantastic incomes. The Board of Trustees of some hospitals may not even be aware of the income produced by some of these percentage arrangements.

Consideration should be given to a contractual arrangement requiring disclosure of the actual levels of compensation produced by these arrangements. Boards of Trustees might consider setting a maximum dollar amount

on any compensation arrangement. Another possibility is to place all hospital-based physicians on fixed dollar salaries.

10. *Denial of Reimbursement for Costs of Some Organizations.*

Hospitals are reimbursed for their dues paid to such organizations as the Delaware Valley Hospital Council and the Hospital Association of Pennsylvania.

Consideration should be given to denial of reimbursement when dues are paid to more than one organization that may render the same services.

11. *Consumer Control of Hospitals.*

Our health delivery system is desperately in need of more consumer input. This is true of Blue Cross as well as the hospitals.

Consideration should be given to an appropriate contractual arrangement to assure adequate consumer representation on hospital Boards and vital committees.

12. *The Hospital: Country Club or Open Institution.*

Every step should be taken to subject the health delivery system to the influences of competition.

One important step in this direction would be authorization of physicians to practice in any hospital rather than imposing country club limitations on what physicians can practice in what hospital.

Consideration should be given to creating an open door policy for all physicians at all hospitals.

13. *Generic Drugs.*

It has been estimated that drug bills might be cut as much as 60 to 95 percent by the use of generic rather than brand-name drugs.

Exhibit 15

One possibility is to have all Blue Cross hospitals follow the procedures already used in several major medical institutions. There the doctor prescribes the drug under the brand-name he knows, on a prescription blank that carries a printed legend over the space for the doctor's signature that says the pharmacist may substitute a less expensive brand where available and identical chemically.

14. *Reimbursement for General Management Surveys.*

Blue Cross contracts may now provide for reimbursement for projects for design and implementation of more effective systems and procedures for furnishing quality patient care.

Such provisions should be broadened to include general management surveys and to otherwise obtain consultation on the basic issues of hospital management.

15. *Incentives for Cost-Saving Programs.*

Various incentives are included in Blue Cross contracts for certain cost-saving programs, such as preadmission testing.

In view of the urgent necessity for economies, consideration should be given to making these cost-saving programs mandatory and doing away with related incentive programs.

16. *Better Accounting for Excluded Research Costs.*

Blue Cross does not directly reimburse for research costs. There is reason to believe, however, that research costs may indirectly be comingled with patient care and thus become reimbursable for Blue Cross. The contract should develop standards to eliminate any reimbursement for research, even if indirect.

Exhibit 15

17. *Public Disclosure of Information.*

The public is entitled to and interested in full disclosure of financial and operational details relating to hospitals.

The contract should give due consideration to making this information available to the public. For example, the cost per day of a hospital stay, average length of stay, aspects of hospital expenses and other facts should be disclosed.

18. *Utilization Review.*

There is a great deal of evidence that the utilization review process is not working effectively and that there is substantial overutilization of hospital facilities.

Consideration should be given to contractual provisions containing new approaches to utilization review. Among suggested variations on the present review process is the inclusion of consumer and financial intermediary representatives on review committees.

19. *Protecting the Patient from Improper Charges.*

The patient is now frequently charged for hospitalization that should never have been ordered in the first place.

In such cases, the hospital should not charge for such services and arrangements should be made for the physician to pick up the tab in such cases.

Consideration should be given to every possible method of protecting the public from improper charges.

20. *Loss Prevention and Control Programs.*

The casualty insurance industry has developed proven methods for eliminating and minimizing hospital accidents

and resulting lawsuits. These lawsuits lead to astronomical costs and insurance premiums, and result in higher Blue Cross premiums.

Consideration should be given to requiring each hospital to implement needed safety measures.

21. *Blue Cross Guarantees of Hospital Bad Debts.*

The Blue Cross contract may now compensate hospitals for bad debts resulting from the inability to collect deductibles, coinsurance exclusions and similar amounts not paid by the applicable Blue Cross contract.

Consideration should be given to transferring the risk of such bad debts from the Blue Cross Plans to the hospitals.

22. *Effective Date of Contract.*

The economies and efficiencies to be built into the Blue Cross-hospital contract should not be unnecessarily postponed even for a day.

Consideration should be given to as early an effective date as possible.

23. *Participation in Hospital Statistical Agency Activities.*

Hospitals should participate in and use services provided by such organizations as the Professional Activities Studies (PAS) or the Hospitalization Utilization Projects (HUP). These services provide comparative data on utilization. Hospitals should also be required to explain any statistical variations significantly above like hospitals. For example, any higher than average stay in any category of major diagnosis should be explained.

24. *Use of Tests Performed Out of Hospitals.*

Hospitals should agree to accept tests and examinations done outside of hospitals by licensed laboratories. Evidence at the Blue Cross hearings indicated hospitals often needlessly duplicate outside tests and often, without good medical reasons, refuse to accept outside tests. This is so, even when the outside laboratories have quality control equal or better than the hospital's own laboratories. In one case, a doctor on the staff of the hospital indicated he could not even use his own outside tests in his own hospital.

25. *More Uniform Accounting.*

Hospitals should be required to move toward more uniform accounting to make the gathering, exchange and analysis of data easier for Blue Cross as well as others.

26. *Greater Use of Systems Departments.*

Should every hospital have a systems department to carry out departmental efficiency studies, with annual reports to Blue Cross? As one fiscal intermediary commented: "A systems department (even if only one talented man and a part-time clerk) can usually justify its existence and cost through review of needs and the establishment of goals and responsibilities, and selecting areas for quick investigation and quick pay-off in improvement of efficiency and cash savings".

27. *Strong Budget Committees with Outside Representation.*

Should every hospital have a budget committee, with outside representatives as well as trustee representatives, and specified composition?

28. *Use of Prudent Buying Practices.*

Special provisions should assure that hospitals are not purchasing merchandise at vastly inflated prices. Evidence at the Blue Cross hearings indicated hospitals may buy such items as scissors, tape measures and furniture through hospital supply companies at many times the cost of identical equipment through conventional channels. For example, one witness at our hearing indicated "hospitals'" tape measures might sell for $2.50 and "hospitals'" scissors for $7.50, but identical products could be bought elsewhere for $.25 and $2.49 respectively.

29. *Use of Departmental Accounting.*

Under Medicare, either the combination or departmental method of accounting may be used. The combination method of accounting results in overcharging Blue Cross subscribers by many millions of dollars. The departmental method presents a much more accurate accounting method and therefore should be used.

30. *Full Recognition of the Impact of the Wage-Price Freeze.*

The consumer is entitled to any savings from the wage-price, and any resulting savings should be built into the Blue Cross-hospital contract.

31. *Greater Consumer and Public Information and Participation in Hospital Board Meetings.*

Hospital Board meetings should be announced in advance and should be open to the public.

32. *Blue Cross Should be More Selective in Deciding What Hospitals to Contract With.*

If a hospital is substandard and does not deliver good quality medical care, it should not have the benefit of a

Blue Cross contract. Blue Cross should establish standards for hospitals and keep raising them from time to time. Eventually, Blue Cross should have contracts only with hospitals which meet all reasonable standards.

33. *Blue Cross Should Have the Right to Put Consultants Into Any Hospital.*

It is clear that hospitals often cover up inefficiencies and are afraid to let expert consultants come in to study them. We think that hospitals should open their doors to consultants as long as any extra costs of such consultants are paid by Blue Cross. Moreover, when the need is indicated, the hospital should have to bring in consultants at its own expense.

34. *Limiting Reimbursements when Occupancy Falls Below a Minimum Level.*

Consideration should be given to a contractual arrangement which would limit Blue Cross reimbursements when the level of occupancy of the hospital falls below a predetermined minimum. It is certain that extremely low occupancy facilities are both uneconomical and unsafe.

35. *Limitations on Reimbursement for Depreciation and Interest on Under-Financed or Excessively Costly Facilities.*

This is necessary to prevent the continued construction of excessively costly hospital facilities.

36. *Disclosure to the Patient of the Doctor's Interest in any Hospital which is Used for any Such Patient.*

A doctor's financial interest in a hospital is another of the flagrant conflicts of interest driving up the cost

of hospital care. Mandatory disclosure will bring a halt to this costly abuse.

37. *Cost Ceilings.*

There should be a maximum on reimbursable per diem costs from one year to the next. These should be done by groups of hospitals as noted in Guideline No. 52.

38. *Board Certified or Board Eligible Surgeons.*

In order to maintain high quality care and reduce the number of unnecessary surgical procedures, Blue Cross participating hospitals should, where practical, allow only board eligible or board certified specialists to practice their specialty. This could be waived for emergencies. In certain cases where this is not practical, the hospital board must publicly and in writing explain the reasons to Blue Shield.

39. *A Hospital Ombudsman.*

Each member Blue Cross hospital should be required to have an ombudsman to handle consumer complaints. The availability of the ombudsman and the formal complaint process should be explained to each patient on entering the hospital or on each use of the outpatient department.

40. *Consumer Advocates Against Physicians.*

When a dispute arises between a patient and his physician, Blue Cross and the hospital, where possible, should act as the patient's advocate. Blue Cross and the hospitals should explore formal methods of achieving this goal.

41. *Patients' Bill of Rights.*

Hospital should make each patient fully aware of his rights when admitted to the hospital. It has been evident that patients have numerous legal rights of which they are not aware while in the hospital. Blue Cross and the hospitals should see that every patient is fully informed.

42. *Counselors for Patients.*

In keeping the patients informed of their rights, alternatives of treatment and other information from admission through discharge, counselors should be available to patients.

43. *Discharge Coordinators on Utilization Review Committees.*

All Blue Cross member hospitals should have active and independent discharge coordinators. The discharge coordinator should be one of the non-physician representatives on all utilization review committees. The discharge coordination should log all discharges and actions and make this information available to Blue Cross.

44. *Questionnaires on Service.*

The hospital administration or the ombudsman should ask each discharged patient to respond to a questionnaire on service developed in conjunction with Blue Cross. The results of these questionnaires should be summarized and made available to Blue Cross on a regular basis. In turn, Blue Cross should use this information in evaluating the hospital for future contractual arrangements. Selected parts of this information might be used in advising consumers.

45. *Log All Hospital Complaints.*

The ombudsman or hospital administration should be required to log each individual complaint. As in the guideline above, this information should be forwarded to Blue Cross.

46. *Arbitration of Complaints.*

A formal and independent process should be established for the arbitration of consumer complaints against hospitals. The patient should have the right to take any complaint to the arbitration and the hospital should agree to go along with the recommendations.

47. *Use of Alternative Food Facilities.*

When patients are ambulatory and can use alternative food facilities, they should be permitted to do so and not be charged for meals in their room.

48. *Clear and Specific Hospital Bill.*

Each hospital should be required to itemize bills to patients in a clear and specific manner so that the patient knows what he is being billed for. Blue Cross might establish a minimum or standard. Each bill should inform the patient of his right to have his questions answered and of his access to complaint mechanisms.

49. *Conflict of Interest Statements by Boards and Key Personnel.*

Hospital boards and key personnel should be required to file annual conflict of interest statements with Blue Cross. Procedures should also be adopted to assure that any board members and other personnel do not participate in making decisions involving them in a conflict of interest situation.

50. *Billing Practices of Hospital Based Physicians.*

When hospital based physicians, such as anesthesiologists, pathologists and radiologists are allowed to bill the patient directly, the cost for care increases and there is a motive for overtreatment and unnecessary procedures. Contract arrangements should not permit such hospital based specialists to bill directly. Arrangements should be made to salary all such personnel. Existing contracts with specialists allowing direct billing arrangements should be terminated and renegotiated within the next six months.

51. *Blue Cross Should Eliminate Advances to Hospitals or Charge Hospitals Interest at Current Market Rates.*

For Blue Cross to make interest free advances to hospitals when other major third party purchasers are not unnecessarily inflates subscriber rates. Blue Cross should either eliminate the advance program or update it to require interest on the money which would be added to other investment income in developing subscriber rates.

52. *Grouping of Hospitals by Size and Function.*

Blue Cross should group hospitals for contractual purposes by size and function. Each of the guidelines could then be best developed to suit the particular class of hospitals. For example, teaching hospitals should be grouped together, large non-teaching hospitals should be grouped together, etc.

53. *Patients' Right to Select Anesthesiologist.*

Arrangements should be made to allow patients to choose the anesthesiologist. The patient should be advised in advance of the names of available anesthesiologists

and when they bill the patient directly, fee schedules should be given the patients.

54. *Patients Should Have Full Knowledge of Who is Performing Procedures.*

Hospitals should be required to inform patients in advance, when possible, of precisely who is performing procedures on them. This would be true for such cases where a nurse anesthetist is administering the anesthesia in place of an anesthesiologist or where the resident performs a procedure in place of the surgeon.

55. *Denial of Benefits for Unnecessarily Long Stays.*

The hospital contract should allow Blue Cross the right to deny portions of hospital stays deemed to be unnecessarily long. The procedure for denial could follow the present Medicare method.

56. *Development of Short Surgical Procedures Capabilities.*

Every hospital which is routinely providing general surgical facilities shall establish a capacity for providing short surgical procedures to outpatients within the next six months.

57. *Denial of Staff Privileges at All Hospitals.*

When one hospital dismisses a physician from its staff for reasons of competence, arrangements should be made for all member hospitals to reciprocate.

58. *Subpoena Notice.*

When a hospital receives a notice to turn over a patient's records, the patient should be notified as soon as possible.

59. *Notification of Malpractice.*

When a hospital discovers malpractice has been performed on a patient, the hospital should be under obligation to notify the patient.

60. *Responsibility of Hospital Trustee.*

The ultimate responsibility for all hospital operations rests with the board of trustees. An effort should be made to make sure hospital trustees are fully aware of their responsibility and that they are fully accepting these responsibilities.

The trustees of every hospital shall immediately establish necessary safeguards to prevent the facilities of the hospital from being made available to any physician for the performance of unnecessary surgical procedures.

61. *Community Effectiveness of Hospital Operation.*

Establish a method whereby at least bi-annually an independent appraisal of the community effectiveness of the operations of every hospital will be made and publicly reported.

62. *Depreciation, if any, Should be Placed in Community Pool.*

If the hospital patients are to pay for depreciation, this money should be placed in a central pool controlled by an independent Board of Trustees representing the patients who provided these funds. They will have the prime responsibility for determining which services or hospitals should be expanded or replaced.

63. *Limitation on the Cost of Nursing Education.*

Blue Cross is today reimbursing large portions of the education costs of schools of nursing. Contract arrange-

ments should be developed to limit cost reimbursement for such programs where services to the patients resulting from the programs are not commensurate to the costs. One approach would be a cost ceiling for reimbursement of such programs.

64. *Hospital By-Laws which Prohibit Physicians from Billing Patients for Unnecessary Admissions and Excess Stays.*

Hospital by-laws should provide that when a stay has been determined excessive or an admission is considered unnecessary by the review procedure, the physician shall agree not to bill the patient for his costs.

65. *Public Hearings on Hospital Budgets.*

A method should be developed to formally present hospital budgets and changes in services to the public before they are submitted to Blue Cross. Public hearings on such budgets and changes would be the best method of gaining public input.

66. *Available Emergency Information on Pharmacies.*

Hospitals should keep consumer information on the location and hours of pharmacies. This information should be made available by telephone as a service to the community.

67. *Implementation of Safety Recommendations.*

The hospitals should agree to implement all safety recommendations suggested by malpractice insurers. If such recommendations are not implemented, a written report as to why they cannot be implemented must be submitted to Blue Cross within 90 days.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Harrisburg

DR. HERBERT S. DENENBERG
The Commissioner

June 6, 1973

Mr. Bruce Taylor, President
Blue Cross of Greater Philadelphia
Philadelphia, PA 19107

Dear Mr. Taylor:

I would like to take this opportunity to add the following guideline to our list which is currently being used in the negotiations between your plan and the Delaware Valley Hospital Council:

Guideline 68

The consumer is entitled to all information concerning the safety and operations of the hospital. To ensure this right, the present contract (Section 28) should be amended to specifically include the public release of all survey reports about the hospital issued by the Joint Commission on the Accreditation of Hospitals.

My staff and I have been carefully reading the transcripts of each of the negotiating sessions as they are forwarded to us. Please continue to keep us informed.

Sincerely,

/s/ HERBERT S. DENENBERG

HERBERT S. DENENBERG
Insurance Commissioner

Exhibit 15

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Harrisburg

The Commissioner

July 16, 1973

Mr. Bruce Taylor
President
Associated Hospital Service of
Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Dear Mr. Taylor:

Once again we should like to add additional guidelines to our list which is currently being used in your negotiations with the Delaware Valley Hospital Council. These guidelines are a result of our continued investigations of the health delivery system in Philadelphia and across the Commonwealth. We will continue to add to our list as further problems come to our attention.

The following are Guideline Numbers 69 and 70:

Guideline 69

It is nationally recognized that smoking is hazardous to the health of the smoker and often annoying to those around him. Such dangers and annoyances are especially true and often multiplied in the hospital environment. The Blue Cross contract should include provisions to separate smoking patients from non-smoking patients and forbid smoking in all areas of the hospital by visitors and staff.

Guideline 70

The langauge problem faced by non-English speaking patients in hospitals and outpatient clinics

Exhibit 15

is of acute concern in many urban areas. Blue Cross participating hospitals should agree to develop a network of translators throughout the area for all hospitals. Such a network could be in a voluntary basis and rely on resources of university language departments and all ethnic organizations in the area. In hospitals that serve large non-English speaking population, arrangements should be made for permanent bilingual staffs and translators.

We have been reading the transcripts of the negotiating sessions which have taken place to date. To say the least, we are disappointed that the hospitals have continued to ignore many of our recent guidelines which most certainly would result in higher quality hospital care at prices the public can afford.

We trust that you will submit these two new guidelines at the negotiations and continue to keep us informed.

Sincerely,

/s/ HERBERT S. DENENBERG

HERBERT S. DENENBERG

Exhibit 15

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Harrisburg

DR. HERBERT S. DENENBERG
The Commissioner

September 18, 1973

Mr. Bruce Taylor
President
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Dear Mr. Taylor:

I am enclosing Guideline 71 to be added to your list of guidelines to be used in the negotiation of the Blue Cross contract with hospitals. Guideline 71 is as follows:

71. *Nondiscrimination At All Levels of Hospital Employment*

Hospitals are important employers of minorities and women, who all too often are found only at the lowest salary and skill levels. Hospitals should commit themselves to a policy of equal employment opportunity for all and should institute programs to eliminate barriers to the upward mobility of their minority, female, and other employees. The Blue Cross contract should include a strong nondiscrimination clause with provisions for reviews to insure compliance.

Best regards.

Sincerely,

/s/ HERBERT S. DENENBERG

HERBERT S. DENENBERG

Exhibit 16

COMMONWEALTH OF PENNSYLVANIA
Milton J. Shapp, Governor

Harrisburg

INSURANCE DEPARTMENT
William J. Sheppard, Acting Commissioner
Contact: David Nestor
Communications (717-787-3289)

FOR IMMEDIATE RELEASE

April 26, 1974

Acting Insurance Commissioner William J. Sheppard today called on the five Blue Cross Plans in Pennsylvania and Pennsylvania Blue Shield to continue their efforts toward controlling hospital costs.

Sheppard said, "Because federal economic controls on the health industry probably will be dropped as of April 30, 1974, the role of Blue Cross in protecting the public from skyrocketing hospital costs will be more important than ever.

"For the past three years, the Pennsylvania Insurance Department has taken a hard line, forcing Blue Cross Plans to negotiate contracts with cost and quality controls. I have no intention of backing away from this. Cost control is more important than ever," said Sheppard.

"Each of Pennsylvania's five Blue Cross Plans has negotiated new contracts with hospitals containing cost and quality provisions drafted by this Department. As a direct result, these contracts have been credited with saving the public many millions of dollars," he said.

Sheppard said, "Both Blue Cross and the hospitals deserve a great deal of credit for progress which has already been made. But we cannot be content to stop here.

Exhibit 16

As new contracts are developed, new methods of monitoring costs and quality must be developed. Further, we must be sure that existing contract provisions are being implemented.

"Some experts have estimated that hospital costs will rise by 16 to 17 percent if economic controls are allowed to expire and new cost controls are not adopted."

Sheppard said, "Since controls over physicians' fees will also be lifted, Pennsylvania Blue Shield must take positive steps to monitor the fees charged its subscribers.

"Working together; Blue Cross, Blue Sheild, hospitals, doctors and State government can keep the costs of health care under control while seeing to it that quality care continues to be provided to the people of Pennsylvania," Sheppard said.

Exhibit 17

HOSPITAL AGREEMENT
July 1, 1971
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Exhibit 17

HOSPITAL AGREEMENT
July 1, 1971

The undersigned hospital (hereinafter called the "Provider") and Blue Cross of Greater Philadelphia (hereinafter called "Blue Cross") in entering this Agreement reaffirm their intent to provide a planned, innovative and efficient health care delivery system to meet the medical needs of the communities they serve. As part of its undertaking, Blue Cross agrees on behalf of each subscriber to the Hospitalization Plan of Blue Cross, Health Service, Incorporated, or other Hospital Service Plan as designated and approved by Blue Cross (hereinafter called "Subscriber") to make those payments required hereinafter and provide its assistance to all area health care institutions in developing procedures and practices to further the goal of a consumer-responsive health care delivery system. The Provider agrees to utilize its best efforts to provide a viable and economical health care delivery system to satisfy the medical needs of the community which it serves.

In order to accomplish the foregoing objectives, the parties hereto, intending to be legally bound, do hereby agree as follows:

Section 1. Provider Services and Facilities.

In consideration of the agreement by Blue Cross to reimburse the Provider as hereinafter described, the Provider agrees:

1.1. To furnish, as applicable, to each Subscriber those hospital services and facilities whereby there may be administered certain medical services incident to hospitalization of the type which Blue Cross is obligated to provide Subscribers (hereinafter called "Covered Services").

Exhibit 17

1.2. That Covered Services shall be available to each Subscriber beginning with the effective date of his Subscription Agreement with Blue Cross (hereinafter called "Subscription Agreement"), except that any waiting periods specified therein may be modified or waived by Blue Cross in such cases as it may determine.

1.3. The Covered Services shall be provided each Subscriber without an advance deposit or charge therefor to the Subscriber except to the extent of any co-payment or deductible amount provided in his Subscription Agreement, including all Form 11 Subscription Agreements (as defined in subsection 1.3.1(d) of Exhibit A hereto), and that, except as aforesaid, Provider will accept the reimbursement provided for herein as the full contract payment of Blue Cross for such Covered Services.

1.4. That its charges for all services to Subscribers shall be the same as its charges to all patients for the same services. The Provider shall file a current schedule of such charges with Blue Cross and furnish written notice to Blue Cross of any modification of such charges at least five days prior to the effective date of such modification. Provider shall also deliver to Blue Cross a copy of the documents required by the policy regulations of the federal Price Commission to be filed with the Medicare intermediary as such relate to any modification in its schedule of charges.

Section 2. Reimbursement by Blue Cross.

Blue Cross agrees to reimburse the Provider for Subscriber admission on or after the effective date of this Agreement for those Covered Services furnished to Subscribers upon receipt of the medical records, if requested, and bills therefor, as follows:

2.1. Reimbursement will be made in accordance with the terms and conditions set forth in Exhibit A attached hereto and made a part hereof, except as otherwise provided herein.

2.2. If Covered Services are furnished as stated dollar allowances or indemnities, except for private room accommodation and indemnities for certain services of physicians, payment of such allowance or indemnity shall constitute final payment by Blue Cross and such Covered Services shall be excluded from any reimbursement calculation required by Exhibit A hereof although such reimbursement shall not preclude Provider from collecting the balance of its charges for such Covered Services from Subscribers.

2.3 If any hospital admission on or after the date of execution hereof, which would otherwise have been Covered Services, is ultimately determined to be medically unnecessary as a result of formal medical review, the Provider shall not charge either Blue Cross or the Subscriber for such an admission. For the purposes of making the foregoing determination, Blue Cross shall advise the Provider's Utilization Review Committee of any case which it has determined to have been medically unnecessary. If the Utilization Review Committee concurs with Blue Cross, such determination will be deemed conclusive unless the physician appeals or if upon review the representatives of Blue Cross and Provider's Utilization Review Committee cannot reach a mutually agreeable result as to a given case, then such case shall be referred, at the expense of Blue Cross, to the appropriate committee of the Philadelphia County or State Medical Society (or such county committee as shall hereafter be created and approved by the Provider and Blue Cross), as applicable, for its determination as to the medical necessity for the

aforesaid hospital admission. It is agreed that the determination of such medical society shall be binding on both Blue Cross and Provider. If a given hospital admission was determined to have been medically unnecessary as a result of the foregoing review procedure, but medically necessary services were furnished which should have been provided on an outpatient basis, Blue Cross shall reimburse Provider for any such Covered Services on an outpatient basis to the extent provided in the Subscriber's Subscription Agreement. However, if the Subscriber insists on hospitalization against the advice of his physician, the Provider may charge any unreimbursed charges to the Subscriber, provided, the Provider has supplied appropriate written evidence to Blue Cross that the Subscriber has been advised of his financial responsibilities.

Section 3. Effective Date.

The provisions of this Agreement are applicable only to Subscriber admissions on or after July 1, 1971 (sometimes referred to herein as the "effective date of this Agreement") and all previous payments made by Blue Cross to the Provider under any superseded contract for such admissions shall be considered to be advance payments subject to the adjustments made necessary by this Agreement.

Section 4. Calculation of Inpatient Days.

4.1. *Inpatient day defined.* For purposes of this Agreement an inpatient day begins at midnight and ends twenty-four hours later. The midnight-to-midnight method is to be used in reporting days of care for Subscribers, even if the Provider uses a different definition of inpatient day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge or a

day on which a patient begins a leave of absence is not counted as a day, but this limitation does not apply to covered ancillary services on the day of discharge. If admission and discharge occur on the same day, such day is considered a day of admission and counts as one inpatient day.

4.2. *Late discharge.* If a Subscriber continues to occupy his accommodations beyond the Provider's regular discharge hour, after being advised prior to such discharge hour that further hospitalization is not required, the Provider may charge the Subscriber for his continued stay. However, if the Subscriber's physical condition is the cause of the stay beyond the Provider's regular discharge hour, the Provider may not charge the Subscriber for Covered Services.

4.3. *Leave of absence.* The day on which a Subscriber begins a leave of absence shall be treated as a day of discharge and not counted as an inpatient day unless he returns to the Provider by midnight of the same day. The day the Subscriber returns to Provider from a leave of absence is treated as a day of admission and counted as an inpatient day if he is physically present at midnight of such day.

4.4. *Limited number of days.* If the Subscription Agreement provides a limited number of days for certain surgical cases, the day on which the operation is performed is included in the days allowed to the Subscriber under the Subscription Agreement.

Section 5. Accommodations.

Semiprivate accommodations including routine general services, which term shall mean accommodations having two, three or four beds per room, are Covered

Services for which the Provider shall be entitled to be reimbursed as determined in accordance with the terms of this Agreement. When accommodations other than semiprivate are furnished, reimbursement for such will be adjusted in the following manner:

5.1. Private Rooms Medically Necessary.

5.1.1. Private rooms or other accommodations including intensive care and other specialty service facilities more expensive than semiprivate will be Covered Services only when such accommodations are medically necessary. Such accommodations shall be considered medically necessary when the attending physician has noted on the Subscriber's medical chart that the Subscriber's condition requires that he be isolated for his own health or that of others.

5.1.2. Isolation may be necessary when treating certain communicable diseases in order to avoid cross-infection, as well as other physical and mental conditions when privacy is necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

5.2. Private Rooms Not Medically Necessary.

5.2.1. When accommodations more expensive than semiprivate are furnished the Subscriber at the time of admission because less expensive accommodations are not available, Blue Cross will reimburse the Provider on the same basis as is applicable to semiprivate accommodations.

5.2.2. When accommodations more expensive than semiprivate are furnished the Subscriber at his request and in the absence of medical necessity, the Provider may charge the Subscriber for the difference between the

charges for the accommodations furnished and the credit for those accommodations included in Covered Services. No such charge may be made to the Subscriber unless he requested the more expensive accommodations with knowledge that he would be charged the differential.

5.3. Wards.

5.3.1. When ward accommodations, which term shall mean five or more beds per room, are furnished the Subscriber at his request, or when semiprivate accommodations are not available at the time of his admission, reimbursement shall be made on the same basis as is applicable to semiprivate accommodations. However, it is understood and agreed that the Subscriber must be moved to semiprivate accommodations when they become available unless the Subscriber specifically requested ward accommodations at the time of his admission.

5.3.2. When ward accommodations are furnished neither at the Subscriber's request, nor due to the lack of available semiprivate accommodations, the reimbursement for ward accommodations shall be on the same basis as is applicable to semiprivate accommodations minus a "ward differential" which shall be computed by calculating the difference between the Provider's customary charges for semiprivate accommodations at its most prevalent rate (the rate which applies to the greatest number of semiprivate beds) in effect at the time of the Subscriber's admission and the charge customarily made for the ward accommodation furnished the Subscriber.

5.3.3. For purposes of administration, when ward accommodations are furnished not at the Subscriber's request, or due to the lack of available semiprivate accommodations, for a period exceeding three days, the entire admission shall be considered a ward admission

and all days charged for this admission shall be adjusted in the manner described in subsection 5.3.2 above. However, when ward accommodations are initially furnished because semiprivate accommodations are unavailable and the Subscriber is subsequently moved to a semiprivate accommodation within three days following the date of admission, the entire admission shall be considered to be semiprivate.

5.4. Specialty Service Facilities.

Reimbursement for the use of intensive care facilities and other specialty service facilities will be made in accordance with subsection 5.1 when such are medically necessary, except where explicitly excluded from Covered Services by the applicable Subscription Agreement.

Section 6. Provider Employees and Private-Duty Nursing.

The reasonable cost of Covered Services rendered by all personnel engaged by the Provider (either on a salary or fee-for-service basis), under arrangements which provide for billing to be made by the Provider, shall be included as a reimbursable cost hereunder.

The cost of private-duty nurses or private-duty attendants (registered professional nurses, licensed practical nurses, or any other trained attendants) whose services are rendered to and restricted to a particular Subscriber by arrangement between the Subscriber and the private-duty nurse or attendant is not reimbursable hereunder.

Section 7. Covered Services Obtained from Outside Sources.

In order to avoid unnecessary duplication of services, the Provider shall institute procedures whereby Covered Services, including timely tests and other timely diagnostic and therapeutic procedures, performed by outside

sources such as pathologists, radiologists and other hospitals, which are licensed pursuant to applicable state regulation, meet the Provider's established quality standards and have been approved by the Provider, will be accepted for use in rendering patient care. Provider shall institute such procedures as may be required for the reasonable regulation of its medical staff directed toward the continued concentration of these tests within its facilities so as to prevent undue escalation of Provider's unit cost for such services. Except for those certain medical services incident to hospitalization provided for in Section 10 hereof, the Provider may not allow those furnishing Covered Services to bill the Subscriber for such services.

Where Covered Services are obtained for Subscribers from such outside sources, reimbursement hereunder shall be made on the basis as though such Covered Services were performed by the Provider. The costs to the Provider shall be used as the reasonable charges for the Covered Services and shall be the amount included in the Subscribers' bills submitted to Blue Cross by the Provider.

Notwithstanding the foregoing, in those cases where the Provider has consolidated any of its ancillary services with those of another health care institution, reimbursement for the Covered Services there performed shall be on the same basis as if such services had been rendered through the Provider's own facilities.

Section 8. Physician Recommendations.

Covered Services shall be rendered to a Subscriber only upon the recommendation of a physician who is a member of the medical staff of, or acceptable to, the Provider and shall continue only during such period as the Subscriber is in need of hospital care for the treatment of illness or bodily injury and is under the care of such a physician.

Section 9. Medical Staff Privileges.

If the Provider is a medical school hospital, the Provider agrees to maintain the standards for staff appointment established by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, as applicable, and the Provider shall grant appropriate medical staff privileges to qualified physicians on the staffs of those hospitals with which it maintains educational affiliations.

Section 10. Arrangements Between Providers and Physicians.

10.1. Reimbursement by Blue Cross.

The Provider and physicians rendering those certain medical services provided for herein may commence, continue, revise or terminate arrangements between them for these services as in their discretion they see fit. In determining reimbursement pursuant to Exhibit A, Blue Cross will recognize the applicable arrangements prevailing between the Provider and such physicians who render certain covered medical services when incident to the hospitalization of Subscribers as provided hereunder.

10.1.1. Under such arrangements when the bills for such covered medical services are included in the Provider's bills rendered to all patients, the compensation paid to physicians rendering those services shall be included as a part of the Provider's cost of those services. After the allocation of costs in accordance with subsection 2.3 of Exhibit A, Part I, the determination of cost of Covered Services to Blue Cross Subscribers shall be made in accordance with subsection 2.2 of Exhibit A, Part I. Blue Cross will pay the Provider the cost of such covered medical services as determined above, thereby

indemnifying the Subscriber against such bills, and in addition will pay to the Provider the amount otherwise payable to the Provider hereunder for the hospital services rendered by it.

10.1.2. Under such arrangements when the bills for such covered medical services are billed directly to all patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills.

The Provider also may have incurred unreimbursed cost in providing the facilities for the rendering of such covered medical services. After the allocation of these costs, if any, in accordance with subsection 2.3 of Exhibit A, Part I, the determination of inpatient cost of Covered Services to Subscriber shall be made in accordance with subsection 2.2 of Exhibit A, Part I, if the Provider has either: (a) complete information with respect to the regular charges for those certain medical services for both Subscribers and all other patients who receive the services; or (b) complete information with respect to regular charges of the Provider made in connection with the rendering of the certain medical services for both Subscribers and all other patients who receive the services. In the event the information required in (a) or (b) above is not available to the Provider, the determination of inpatient cost of Covered Services to Subscribers shall be made as follows: (i) on total occasions of such inpatient medical service or a statistical basis of allocation approved for such use in Title XVIII of Public Law 89-97 (hereinafter called "Medicare") apportioned between Subscribers and other patients; or, if this information is not

complete, (ii) on total inpatient admissions apportioned between Subscribers and all other patients. Blue Cross will pay to the Provider the cost of such covered medical services as determined above and in addition will pay to the Provider the amounts otherwise payable to the Provider hereunder for the hospital services rendered by it.

10.1.3. Under such arrangements when the bills for any one of the certain medical services incident to hospitalization are included in the Provider's bill rendered to some patients, and when bills for such medical services are billed directly to some patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it as are billed directly by such physicians, of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills. The Provider's cost of such medical services shall be subdivided into those applicable to services billed for by the Provider and those applicable to services billed for by the physician. The cost of covered medical services for each of these categories shall then be determined in accordance with the methods described in subsections 10.1.1 and 10.1.2 above, as appropriate. Blue Cross will pay the Provider its cost as so determined.

10.1.4. Under such arrangements when the bills for certain medical services incident to hospitalization have been billed directly to patients by such physicians, the Provider may have incurred cost in providing the facilities for the rendering of such covered medical services in return for an agreed upon payment by the physiciar to the Provider. Payments received by the Provider under such an arrangement shall be treated as a reduction of allowable cost of the Provider to the extent of such cost.

10.1.5. In the event the Provider has elected to be reimbursed on a prospective rate basis in accordance with Part II of Exhibit A, the Provider agrees that: (a) the amounts payable directly to physicians by Blue Cross under subsections 10.1.2 and 10.1.3 above shall be excluded in the determination of such gross prospective rate; (b) the amounts otherwise payable by Blue Cross to the Provider for costs the Provider may have incurred in providing the facilities for rendering such medical services pursuant to subsections 10.1.1, 10.1.2 and 10.1.3 above shall be incorporated in the determination of such gross prospective rate and no additional payment will be made by either Blue Cross or the Subscriber; and (c) the payments received by the Provider pursuant to subsection 10.1.4 shall be deducted in making the determination of such gross prospective rate otherwise payable to the Provider by Blue Cross. To ensure that the gross prospective rate adequately reflects the costs to Provider of the various arrangements which it has with physicians rendering such covered medical services, Provider shall notify Blue Cross of any modification or amendments to such arrangements and in such events Blue Cross will make appropriate changes in the gross per diem rate.

10.2. Reporting Requirements.

The Provider shall report annually to its governing board or a committee thereof the actual compensation or if unknown, an estimate, received by each of the anesthesiologists, pathologists and radiologists on its staff for services to the Provider's inpatients and outpatients.

Section 11. Utilization Review.

11.1. The Utilization Review Program.

11.1.1. The Provider shall maintain or create and maintain, as appropriate, a program of utilization review

which shall be implemented by a Utilization Review Committee whose membership shall include the Provider's Administrator or his designee, and at least one non-physician member of its governing board.

11.1.2. The Provider shall forward to Blue Cross a copy of the Utilization Review Plan which it has previously filed with the appropriate state agency and as such Plan is changed or modified shall advise Blue Cross accordingly.

11.1.3. The Provider will strive to improve the effectiveness of its Utilization Review Plan by exerting special efforts in reviewing:

(a) Lengths of stay;

(b) Promptness of service;

(c) The medical necessity of admissions;

(d) Use of consultations;

(e) Implementation of effective discharge planning; and

(f) Such other efforts and procedures as will minimize unnecessary use of expensive medical resources and ensure proper patient care.

11.2. Review of Admissions.

The Provider shall have all elective cases reviewed within 72 hours [excluding Saturdays and Sundays] following the patient's admission and establish an expected length of stay for each such case based on the admission diagnosis. Any variations between such established and experienced length of stay shall be investigated by the Utilization Review Committee. Non-elective cases will be reviewed by the Utilization Review Committee on a biweekly basis.

11.3. Reporting Procedures.

In the event Provider does not subscribe to the Hospital Utilization Project (HUP), Professional Activity Study (PAS) or similar reporting service, Blue Cross shall furnish to the Provider data indicating the average lengths of stay for the most frequent diagnoses in this general geographic area and a quarterly listing, itemized by diagnosis, of the Provider's experienced length of stay for Subscribers. If any quarterly study of HUP, PAS or Blue Cross supplied data indicates that the Provider's experienced average length of stay for any major diagnosis is more than ten percent longer than the area average, the Utilization Review Committee shall determine the basis for this variance and submit a written explanation of the causes with suggested corrective measures to its governing body, with a copy of this report being forwarded to Blue Cross. All comparisons required above shall be made with reference to data for patients under age 65.

11.4. New Services.

Any additional cost which Provider incurs as a direct result of an expansion, increase or modification of its existing services in order to satisfy the requirements set forth in subsections 11.2 and 11.3 shall be a reimbursable cost hereunder and treated as a new service as provided for in subsection 18.4.2 hereof.

Section 12. Cost Saving Programs.

Provider shall, to the extent practicable, actively participate on a continuing basis in the following Blue Cross programs or equivalent programs approved by Blue Cross which seek to encourage the effective use of Provider's inpatient facilities: (a) preadmission testing, (b) short procedure unit, (c) home care service, and (d) planned discharge.

Section 13. Systems Analysis.

In order to provide a means whereby more efficient methods of operation may be developed and implemented, the Provider shall assign one or more administrative employees the responsibility for systems analysis directed toward accomplishment of this objective.

Section 14. Use of Modern Management Techniques.

14.1. The Provider may during the term of this Agreement undertake a comprehensive study of its operating and administrative procedures utilizing one or more independent consulting agencies to assure an optimal organizational structure and fix staffing levels for each of its departments, using objectives acceptable to both the Provider and Blue Cross. Further, it is agreed that any such study may be undertaken with other hospitals on a joint basis, and if the Provider has commenced or is continuing any such study, said study will satisfy the terms of this Section for the periods subsequent to July 1, 1971 if it has received the approval of Blue Cross. The cost of any such study shall be included in the operating costs of the Provider which are reimbursable in accordance with this Agreement for the applicable fiscal year in which payments are made.

14.2. If the study described in subsection 14.1 above is initiated by Provider, or other general or special management studies are undertaken which are determined by Blue Cross to be consistent with this Agreement, and if initial implementation of the recommendations produced by such study is commenced within six months immediately following the date of such recommendations, Blue Cross will make an unrestricted grant separate and apart from any other reimbursement required by this Agreement, based on the total cost of such study up to

$100 per bed annually ($300 per bed annually in the case of general management studies). The foregoing grant shall be in a sum equal to the amount obtained by determining the maximum allowable per diem cost of the study applicable to all inpatient days during such fiscal year which have been provided to other than free and part-pay patients and multiplying such allowable per diem cost by the number of Blue Cross inpatient days provided during the applicable fiscal period.

14.3. In order to ensure that the recommendations of the foregoing studies are available for use by other health care institutions seeking to develop cost-saving programs, the Provider shall furnish to Blue Cross on a scheduled basis a summary of all reports and relevant data regarding the results and implementation of its studies so that such information may be periodically distributed to other area hospitals.

Section 15. Modification of Reimbursement.

The Provider and Blue Cross agree that reimbursement for Covered Services by Blue Cross will be for services of high quality furnished as efficiently and economically as possible, and paid for in the most effective and equitable manner that can be devised. In recognition of this objective, the parties hereto agree that reimbursement hereunder may be modified by the mutual agreement of the Provider and Blue Cross. Any such modified reimbursement shall become effective for admissions on and after the first of the month next following such modification, or as soon thereafter as reasonably possible.

Section 16. Generic Equivalents.

16.1. If the Provider has on its staff a full-time pharmacist, it shall maintain a Drug Formulary Committee either of its own, or in cooperation with area hospitals, which will develop and implement a program designed to ensure that drugs are dispensed by generic rather than brand name when the less expensive generic equivalent is available. As part of this program, Provider will utilize prescription blanks which contain a printed legend authorizing the pharmacy filling the prescription to dispense, when available, generic equivalents for the brand name drugs prescribed.

16.2. In developing the drug formulary program, it is recognized that in certain situations it may be necessary and prudent for the prescribing physician to designate a specific brand name drug due to compounding differences in the generic equivalent. To allow for these unusual situations, the Provider may make suitable internal arrangements provided the physician requiring such brand name drugs makes an appropriate notation on the patient's medical chart or similar record. The Provider shall maintain in sufficient detail suitable records and other data which will be reviewed by the Drug Formulary Committee and made available for inspection by Blue Cross.

Section 17. Cooperation Between the Provider and Blue Cross.

The Provider and Blue Cross agree to cooperate fully with each other in administering the various provisions of this Agreement. To this end, Blue Cross shall promptly furnish Provider such information as is necessary to verify the payments made to it by Blue Cross. Blue Cross shall submit to the Provider upon request: (a) monthly financial reports of its operations and its current balance sheet position; (b) annual financial balance sheets and income and surplus statements as certified by independent accountants within thirty days after the receipt thereof

from the accountants; and (c) copies of all transactions and financial operating data having a bearing on this Agreement. Similarly, Provider shall submit to Blue Cross all cost information regarding its operations which is necessary for the administration of this Agreement, and will permit Blue Cross to examine and audit all records, documents, and financial and statistical data which may relate to reimbursable costs as determined herein.

Section 18. Budgetary Review Procedures.

18.1. Submission of Budgets.

Provider shall submit its annual budget to Blue Cross at least forty-five days prior to the first day of Provider's fiscal year on the standard form which is attached hereto as Exhibit B, as such may be modified from time to time. The budget shall include a proposed gross inpatient per diem rate for interim payments by Blue Cross to Provider. The budget as submitted to Blue Cross shall have had the prior approval of Provider's Budgetary Committee or similar financial committee, the membership of which shall include at least one member of Provider's governing body. For Provider's first fiscal year under this Agreement, the foregoing requirement may be satisfied by submission of Provider's budget in its own format with comparative information in such reasonable detail as is necessary to distinguish inpatient and outpatient costs, determine the effects of any wage-price stabilization policies on anticipated costs in the budgeted year, and permit line comparisons with previous years' budgets and financial results of operations as soon as reasonably possible after the execution of this Agreement, but in no event later than 30 days after the execution hereof. The budgets submitted in accordance with this subsection 18.1 shall include all adjustments made necessary by the application of federal price stabilization requirements.

18.2. Interim Payments.

Blue Cross shall review the data submitted by Provider to determine the reasonableness of the expenses included therein in accordance with the provisions contained in Exhibit A hereof utilizing the following procedures:

18.2.1. If Blue Cross shall determine that the estimates set forth in the budget submitted by the Provider are reasonable within the meaning of subsection 2.1 of Exhibit A, Part I hereof, Blue Cross shall so advise the Provider and use the gross inpatient interim per diem rate proposed by Provider for admissions during such budgeted fiscal year.

18.2.2. If Blue Cross determines that the cost estimates included in Provider's budget as submitted are unreasonable, or that the gross inpatient interim per diem rate proposed by Provider has not been properly computed, Blue Cross shall within forty-five days of its receipt of said budget so advise Provider and request a meeting with Provider's representatives to review the matter and determine whether appropriate modifications should be made in the budget or the gross inpatient interim per diem rate. If Blue Cross does not so advise Provider within the aforesaid forty-five day period, Blue Cross shall reimburse Provider based on the gross inpatient interim per diem rate proposed by Provider until such time as a meeting can be held to review the reasonableness of Provider's budget.

18.2.3. If Provider and Blue Cross are unable to reach agreement as to the reasonableness of the budgeted costs, Blue Cross shall determine the gross inpatient interim per diem rates for the budgeted year based upon its review and findings, considering any supplemental data submitted by Provider. In such event, Provider may exercise its

right of appeal as set forth in Section 21 hereof, accepting the interim rate set by Blue Cross until a final decision is rendered by the Appeals Board or Court, as appropriate. However, it is expressly understood by the parties hereto that the foregoing right of appeal shall pertain only to gross inpatient interim per diem rates as determined above and does not extend to any rate fixed pursuant to subsection 18.5.

18.2.4. When the gross inpatient interim per diem rates have been based on unaudited data, such rates shall be subject to appropriate increase or decrease retroactively and prospectively if the net audit adjustments, excluding non-recurring items, amount in aggregate to more than one dollar ($1.00) per patient day subject to the limitations contained in subsection 18.4.

18.2.5. All gross inpatient interim per diem rates established pursuant to this Agreement shall be subject to review and adjustment in the event a major unforeseeable and unanticipated cost increase or decrease occurs during the fiscal year, in which case the Provider shall so advise Blue Cross promptly of such changes and forward to Blue Cross the appropriate supporting data.

18.3. Quarterly Reports.

Provider shall submit quarterly to Blue Cross its statement of current operating costs within seven days following the date when such are reviewed by its governing board or financial committee. The statement as submitted to Blue Cross shall show the actual operating experience of Provider with budget comparisons for such period.

18.4. Limitation on Reimbursement.

The reimbursement to be paid Provider by Blue Cross as either an interim rate or pursuant to the auditing

procedure set forth in Exhibit A shall be subject to the following limitations for the fiscal year 1971-72:

18.4.1. Subject to subsections 18.4.3 and 18.4.4 hereof, the maximum total allowable cost, upon which Blue Cross reimbursements to the Provider shall be based, for the fiscal year 1971-1972 shall be limited to 112% of the actual total allowable costs of the Provider approved by Blue Cross for the fiscal year 1970-1971.

18.4.2. In calculating the maximum total allowable cost of the Provider for the fiscal year 1971-1972, such computation shall exclude the cost of the joint study provided for in subsection 1.4.6 of Exhibit A, Part I and all depreciation allowances applicable to the 1970-1971 and 1971-1972 fiscal periods, and shall make appropriate additions or reductions in the fiscal 1970-1971 cost to reflect changes in services or facilities initiated or deleted by the Provider so as to annualize the two periods for comparison purposes.

18.4.3. The maximum total allowable cost to be permitted Provider under this Agreement may be adjusted for unanticipated cost amounting in the aggregate to more than ten cents ($0.10) per patient day (including payments by Provider required by Sections 14 and 24 as well as the cost associated with implementing the recommendations of studies made pursuant to Section 14 hereof) when such cost (a) is beyond the control of Provider or is required by an accrediting body or governmental agency, (b) was not foreseeable at the time the annual budget was submitted to Blue Cross, and (c) is adequately demonstrated by appropriate records of the Provider.

18.4.4. In the event arrangements between the Provider and physicians rendering covered medical services as described in Section 10 hereof are initiated, modified,

revised or terminated with the result that the Blue Cross payments to Provider for such covered medical services are modified, the 1970-1971 approved cost used in calculating the maximum reimbursement for purposes of subsection 18.4.1 shall be adjusted accordingly.

18.4.5. In the event the Provider determines it is unable to maintain its cost as computed in accordance with Exhibit A hereof within the maximum limitation established by this subsection 18.4, the Provider may elect to terminate this Agreement upon providing Blue Cross fifteen days prior written notice of such intent to terminate. In such case the obligations set forth in Section 27 shall apply and the interim payments provided for herein shall be continued at the rate then in effect subject to such modification as any subsequent contract may require.

18.4.6. The limitation on total allowable cost, if any, for 1972-73 will be negotiated during the six month period immediately prior to July 1, 1972. In determining any such subsequent limitation it is agreed that the information supplied by Provider pursuant to subsection 18.1 shall serve as the basis for such negotiations. If agreement is not reached by July 1, 1972 this Agreement shall terminate as of such date subject to Section 27 hereof.

18.5. Prospective Rating.

Provider may elect in lieu of the reimbursement otherwise payable by Blue Cross under this Agreement to negotiate a fixed inpatient per diem rate of reimbursement which shall be payable no less frequently than semimonthly to the Provider by Blue Cross. Such fixed rate will be determined to the mutual satisfaction of the parties hereto, based on the Provider's budget as submitted in accordance with subsection 18.1 hereof and the 1970-1971 per diem cost as approved by Blue Cross using

as the basis for such determination the projected costs as developed from application of the Principal set forth in Part I of Exhibit A.

In fixing such a prospective rate, the limitations set forth in subsection 18.4 hereof, and subsection 1.4 of Exhibit A, Part I, as applicable, will provide a ceiling for such rate. If there is a change in the arrangements described in Section 10 hereof, an appropriate concurrent change in the prospective rate will be made. Moreover, it is agreed that such rate will not be subject to review or appeal pursuant to Section 21 and the Provider will be permitted to retain for improvement of services all overage received by achieving a cost which is below the prospective rate or be required to absorb any deficiency if during the appropriate fiscal period its costs should exceed payments received under the negotiated prospective rate.

Any grants, other than mere reimbursement for expenses incurred, to be made to Provider by Blue Cross in accordance with Section 14 of this Agreement shall be separate and apart from the amounts to be paid pursuant to this subsection 18.5. All prospective rates shall reflect the effect of any wage-price freeze on hospital budgets and costs so as to satisfy all applicable federal price stabilization requirements and, where made necessary by the occurrence of any unanticipated and unforeseeable happening, be adjusted in accordance with subsection 18.4.3.

Section 19. Purchasing Procedures.

Provider's governing board, or a committee thereof, shall review the practice and procedures of its purchasing officers and agents to insure that the "Prudent Buyer Concept" is employed when making purchases of equip-

ment, supplies and services. The reports and statistical data used by the purchasing officers and agents shall be made available to Blue Cross for review.

Section 20. Professional Liability-Safety Control Program.

In order to maintain a comprehensive program of loss control and loss prevention, the Provider shall establish or maintain, as applicable, a safety program based on the American Hospital Association's "Hospital Safety Manual" and incorporating the principles set forth in Exhibit C attached hereto and made a part hereof.

Section 21. Right of Appeal.

21.1. In the event of any disagreement between the parties hereto concerning the application, operation or interpretation of this Agreement, other than as expressly excepted herein, either party hereto shall have the right to refer the matter to an Appeals Board composed of three or five members as specified in the written notice of the Appellant initiating the appeal (except that if such notice specifies three members the answer of Appellee may increase the number to five). The notice of appeal shall name Appellant's representative to the Board and the answer of Appellee shall name its representative to the Board. If the answer of Appellee is not served on Appellant within two weeks after Appellee's receipt of the notice of appeal, Appellee's representative shall, at the request of Appellant, be named by the President Judge of the Court of Common Pleas of the county where Provider is located, or such other judge of that court as he shall designate. The representatives of Appellant and Appellee shall promptly meet and select the other members of the Appeals Board. If they fail to make such selection within thirty days of the designation of Appellee's representative, the selection of the other members shall be similarly made by such President Judge or a judge of that court designated by him. The cost associated with the foregoing appeals procedure shall be borne equally by the parties thereto and the Provider's share of such cost shall be included as a reimbursable cost hereunder, provided, however, that the Appeals Board shall have the power to determine whether the Provider has been unreasonable in forcing the disagreement to arbitration, and if so, the Appeals Board may or may not exclude all or any part of the Provider's share of such cost as a reimbursable cost hereunder.

The Appeals Board shall conduct a formal hearing as to the matters set forth in the notice of appeal and thereafter forward its adjudication to the Provider and Blue Cross within sixty days after the hearing is closed. The adjudication shall be in writing and signed by the majority of the Board members hearing such appeal. If within thirty days after receipt of the Board's adjudication either party is aggrieved thereby, it shall have the right to appeal such adjudication to the appropriate court of competent jurisdiction which shall hear the case *de novo*. In the event an appeal is taken within the aforesaid thirty day period, such appeal shall operate as a supersedeas without further action by the appeals court or the parties hereto.

21.2. No action at law or in equity in connection with the application, operation or interpretation of this Agreement shall be instituted by either party until it has exhausted the right of appeal hereunder. In addition, no action at law or in equity shall be maintainable by either party to this Agreement against the other party hereto for any claim arising out of this Agreement unless such action be brought within two years from the date when the

cause of action arose, provided, however, that this limitation shall not preclude the appeal provided for in subsection 21.1.

Section 22. Status of Provider and Blue Cross.

22.1. The Provider hereby represents that it is a nonprofit institution approved by either the Joint Commission or Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association and as such is approved or duly licensed as required by state law. If the Provider's status or method of operation changes during the term of this Agreement it will immediately notify Blue Cross of such change.

22.2. Blue Cross hereby represents that it is a corporation duly organized and existing under the laws of the Commonwealth of Pennsylvania for the purpose of operating a nonprofit hospitalization plan and is licensed to use the Blue Cross name and insignia. If Blue Cross' status or method of operation changes during the term of this Agreement it will promptly notify the Provider of such change.

Section 23. Accreditation.

In order to encourage the Provider to satisfy recognized minimal standards in providing patient care, Provider agrees to strive for accreditation by the Joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association. In the event the Provider is not so accredited Blue Cross shall have the right, notwithstanding any other provision contained herein, to terminate this Agreement upon giving the Provider thirty days prior written notice of such intent to terminate.

Section 24. Planning of Health Care Facilities.

24.1. Major Construction of Facilities.

If the Provider undertakes any project for the replacement or expansion of its facilities and equipment at an estimated cost in excess of $250,000, it will submit such project to the Hospital Survey Committee, Inc., ("HSC") for review prior to the letting of contracts therefor.

24.2. Expansion of Certain Services.

If the Provider undertakes a project to provide either a new service listed below or expand an existing service listed below in such a way as to require in any one fiscal year additional space (beyond that theretofore used for such service) greater than 10% of the space theretofore so used, it will submit such project to HSC for review prior to the letting of contracts therefor. The services referred to in this subsection are the following: (a) megavoltage radiation services; (b) open-heart surgery services; (c) obstetrical services; (d) pediatric services; (e) operating room services; (f) emergency care services; (g) diagnostic radiological services; (h) hemodialysis services; (i) burn treatment services; (j) other services acceptable to Provider as criteria are developed by HSC.

24.3. Change of Function.

In addition to the requirements set forth in subsections 24.1 and 24.2 hereof, if Provider has obtained the prior endorsement of HSC for a given facility and desires within three years of such endorsement to change the function of such facility or a substantial portion thereof, it shall submit and obtain the endorsement of HSC for such change prior to the implementation thereof.

24.4. Denial of Reimbursement.

If HSC refuses to endorse a project reviewed by it pursuant to subsections 24.1, 24.2 or 24.3 within 90 days after it has received all pertinent data requested by it from the Provider and the Provider, nevertheless, carries out the project, Blue Cross reimbursement to the Provider will be calculated before any allowance for depreciation or interest expense with respect to the facilities of such project as to subsections 24.1, 24.2 and 24.3 or the services supplied by such project with respect to subsection 24.2. If a project is submitted for HSC endorsement which HSC considers not within the purview of this Agreement, it shall so advise the Provider within 90 days of such submission and this subsection 24.4 shall not apply to such project.

24.5. Periodic Evaluation; Elimination of Facilities.

The Provider shall permit HSC to evaluate once every three years, but only at a time when Provider is bound by a contract containing substantially the same provisions as this Section 24, the need for existing facilities of, and services supplied by, the Provider. The evaluation shall cover facilities which do not conform to the then current requirements for new construction in respects which render them unsafe for patients. If the report of HSC as submitted to Blue Cross and the Provider recommends that a facility or a service of Provider is no longer needed, it shall specify a reasonable time period by the end of which the facility or service must be eliminated. Similarly, if the report states that a facility is unsafe, it shall specify a reasonable time period by the end of which the facility must be made safe or eliminated. After the end of a period so specified, Blue Cross reimbursement to the Provider shall be calculated without any allowance for the cost of facilities or

services not eliminated or made safe in accordance with such evaluation, unless Provider is expressly prohibited from eliminating such facilities or services by law.

24.6. Agreement for the Financing of the Activities of HSC.

HSC has agreed to perform the services described in Section 24 "Planning of Health Care Facilities", for the period January 1, 1972 to June 30, 1973 in consideration of the amount of $620,000. The Provider agrees to pay its proportionate share of this $620,00 cost and Blue Cross agrees that the Provider's proportionate share of this expense shall be included in the Provider's total allowable cost in the amount incurred for each fiscal year, or portion thereof.

24.6.1. Provider's proportionate share of the total cost of services to be performed by HSC pursuant to this Agreement shall be determined first as a percentage by dividing the Provider's total allowable cost by the total aggregate allowable costs of all Providers contracting with Blue Cross participating in "Planning of Health Care Facilities." Such percentage shall then be applied to the $620,000 total cost of the services of HSC to determine the dollar amount of each Provider's proportionate share. The total allowable costs for the fiscal year 1969-1970 shall be used in determining the Provider's proportionate share.

24.6.2. Method of Payment.

To provide HSC with the cash flow necessary to provide the services detailed in this Agreement from one source and to eliminate an adverse effect on the Providers' cash flow during any fiscal year, Blue Cross shall on the behalf of all Providers contracting with Blue Cross and participating in "Planning of Health Care Facilities,"

pay monthly to HSC an amount equivalent to 1/18 of each Provider's proportionate share of the agreed $620,000 which sum represents the total cost of the service for the 18 month period January 1, 1972 to June 30, 1973.

Blue Cross shall advise each Provider as to the amount and date of all payments made on its behalf to HSC and record such payment on Blue Cross' books as a special advance supplementary payment for each Provider which shall be separate and apart from any other advance or interim payments provided under this Agreement. Such special advance supplementary payments made by Blue Cross on behalf of the Provider pursuant to this Section 24 shall be included in the calculation of any "Retroactive Adjustment" as provided in subpart 2.4.5 of Exhibit A, Part I, for the fiscal year in which such payments were made.

24.6.3. Reimbursement by Blue Cross.

In calculating Blue Cross reimbursement, Provider shall include its proportionate share of the total cost of services to be performed by HSC in its administrative cost using an approved method of cost finding in accordance with subsection 2.3 of Exhibit A, Part I, and allocated in accordance with the approved method pursuant to subsection 2.2 of Exhibit A, Part I.

It is anticipated that the activities of HSC in the "Planning of Health Care Facilities" and the periodic review and evaluation of services will result in more effective use of hospital facilities and services, and reductions in the cost of rendering health care services in the total area covered. In many cases the reductions in costs realized will exceed the cost of HSC services to the Providers. These benefits will accrue to all institutions participating, and the various classes of patients and third party payers that they serve. Therefore, the Provider's proportionate

share of the HSC cost shall be shared by self-pay patients, Medicare, Medicaid, Blue Cross and/or any other third party payer. However, the one small segment of patients for which reimbursement of this cost will not be received, are those determined to be free.

In recognition of the potential benefits to be derived from this program in the containment of health care costs which will inure to Blue Cross subscribers, as well as to the community at large, Blue Cross agrees to assist each Provider to recover a portion of this cost as follows:

Blue Cross shall make an unrestricted grant annually at time of final settlement, separate and apart from any other reimbursement required by this Agreement, in an amount equal to 50% of that portion of the Provider's HSC expense applicable to the free work for which no reimbursement would otherwise be received. The calculation of the amount of this grant shall be made in the following manner:

> Calculate the percentage that the free work charges are to the total charges for the fiscal year 1969-1970. Multiply the total Provider's proportion of the HSC expense by this percentage, 50% of the resulting proportion attributable to free work of the HSC expense will be reimbursed by Blue Cross in addition to that portion calculated to be payable by the R.C.C.A.C. apportionment of Blue Cross' liability for Covered Services rendered to Subscribers.

The amount of this unrestricted grant is not to be included in the calculation of any "Retroactive Adjustment" as provided in subpart 2.4.5 of Exhibit A, Part I, of this Agreement.

Section 25. Superseded Contract.

The provision of any contract between Blue Cross and the Provider which this Agreement supersedes to the

contrary notwithstanding, the payments to be made by Blue Cross under said superseded contract to the Provider for all admissions prior to the effective date of this Agreement shall be at the rate in effect under said superseded contract at the date of such admission. The Provider shall not be reimbursed or paid by Blue Cross for any incentive payments it would have earned or otherwise been entitled to under any of the Principles numbered 2-5 through 2-9 inclusive, which were added to Exhibit A of the superseded Provider-Blue Cross Contract (Uniform Cost Contract 1967) by the July 1, 1970 amendment, except as to those incentive payments which were earned prior to July 1, 1971.

Section 26. Term of Agreement.

26.1. Subject to the provisions contained herein, this Agreement shall remain in effect until July 1, 1973, although it may be terminated earlier by either Provider or Blue Cross upon ninety days prior written notice to the other party or as provided in subsection 18.4 and Section 23 hereof.

26.2. In the event this Agreement terminates as provided heretofore, any depreciation allowed as a result of a subsequent contract between Blue Cross and the Provider shall be calculated using the asset basis and method established in accordance with Part I of Exhibit A.

Section 27. Obligations after Termination.

In the event this Agreement terminates for any of the reasons set forth herein, the Provider, if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the

time of their admission to the Provider, and (a) who were admitted to the Provider or treated as outpatients during the ninety day period following the date of such termination; or (b) who were inpatients on the date of such termination; or (c) who were admitted to the Provider during the unexpired portion of their agreement year current at the termination, i.e., the date 90 days after the delivery of notice of termination under subsection 26.1 or the similar date under other sections.

Section 28. Public Disclosure.

Provider and Blue Cross mutually agree that the public at large has a significant and continuing interest in the development of an effective, cost-efficient medical service program which is responsive to consumer needs. To ensure that the public is advised of the plans, programs and undertakings of both the Provider and Blue Cross, each party agrees that during the term of this Agreement they shall individually make available information relating to costs, facilities, services available and other pertinent financial and statistical data with respect to their own operation, and continue appropriate measures to assure adequate consumer participation in their respective activities.

Section 29. Section Headings.

The section headings used herein have been inserted for convenience of reference only and shall not in any way modify or restrict any of the terms or provisions hereof.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have caused these presents

Exhibit 17

to be executed by their proper officers as of the date of execution set forth below.

Date of Execution

_____ _____
Name of Provider

Effective Date

July 1, 1971 By _____
Signature

_____
Title of Signing Officer

BLUE CROSS OF GREATER PHILADELPHIA

_____
President

Exhibit 17

EXHIBIT A

PRINCIPLES OF REIMBURSEMENT

For purposes of establishing the amounts to be paid Provider by Blue Cross pursuant to this Agreement, Provider shall have the option during the term of this Agreement of being reimbursed on the basis of either a "Reasonable Cost" or "Prospective Rate" as such are more fully described hereinafter. The Provider must advise Blue Cross in writing which method it has elected prior to the end of the second month of the prospective fiscal year (for the first year of this Agreement such election must be made within thirty days following the execution of this Agreement). This election once made by Provider may not be changed for such fiscal year. In the event Provider fails to make an election within the prescribed period or is unable to reach agreement with Blue Cross on a Prospective Rate, the reimbursement to be paid Provider shall be calculated on the basis of "Reasonable Cost" as provided for in Part I of this Exhibit A.

PART I. REASONABLE COST BASIS

It is the intention of the parties hereto that application of the Principles set forth in Sections 1 and 2 hereof shall be made utilizing all current and future applicable Medicare interpretations, instructions and manuals containing informational and procedural matter as regards the various determinations of cost under these Principles, except where the Principles would make such material inappropriate.

No amendment to the Medicare Law nor change in the sections of the Medicare Regulations which are captioned "Principle" as were promulgated on July 1, 1967 shall be applicable to this Agreement.

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Section 1. PRINCIPLES TO BE USED IN DETERMINING SPECIFIC REIMBURSABLE COSTS.

1.1. Allowance for Depreciation Based on Asset Costs.

Principle

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation to be allowed under this Agreement must be:

(a) Identifiable and recorded in the Provider's accounting records from the date of acquisition or appraisal if not recorded upon acquisition; and

(b) Based on the historical cost of the asset (including assets financed with Hill-Burton or other federal or public funds) or fair market value at the time of donation in the case of donated assets; and

(c) Prorated over the remaining estimated useful life of the asset as in use as of July 1, 1971, using the straight-line method and based on the remaining undepreciated value, if any, of the asset as of July 1, 1971 with respect to depreciation taken for Blue Cross purposes under previous contracts between the Provider and Blue Cross.

1.1.1. Definitions.

(a) *Historical cost* is the cost incurred by the present owner in acquiring the asset.

(b) *Fair market value* is the price which the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.

Exhibit 17

(c) Under the *straight-line method of depreciation* the cost or other basis (e.g. fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is first determined. This sum is then distributed equally over the estimated useful life of the asset.

1.1.2. Recording of Depreciation.

Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, the assets' historical costs, estimated useful lives, and the assets' accumulated depreciation used for Blue Cross purposes. The "Chart of Accounts" published by the American Hospital Association shall be used as a guide in determining the estimated useful lives of assets.

1.1.3. Funding of Depreciation.

Although funding of depreciation is not required it is strongly recommended that Providers use this mechanism as a means of conserving funds for replacement of depreciable assets and coordinate their planning of capital expenditures with areawide planning activities of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

1.1.4. Gains and Losses on the Disposal of Depreciable Assets.

Gains and losses realized from the disposal of depreciable asets are to be included when computing allowable costs. If the gains or losses on the disposal of depreciable assets in a given fiscal year are greater than 10% of the total allowable depreciation for that period, the amount of gain or loss in excess of 10% must be carried forward

over the next five succeeding years. Proper books of account identifying the gain or loss carry-forward for each individual year must be separately maintained by Provider and any such carry-forward shall be considered first in determining the aforesaid 10% limitation for any year.

The amount of such gains and losses which are includable in allowable costs shall be calculated as follows:

(a) When an asset which was acquired by Provider before the date it entered into a "cost-type contract" with Blue Cross (hereinafter called the "Entry Date") is disposed of, a correction of prior years' depreciation based on actual life must be made before determining any gain or loss. The depreciation accumulated before the Entry Date must be corrected in the same manner as when making a new estimate of the asset's useful life. The gain or loss is the difference between the amount received for the asset and the corrected undepreciated cost at time of sale.

(b) Gain or loss on the disposal of assets acquired after the Entry Date is the difference between the sale price of the asset and the asset's unrecovered cost.

1.1.5. Establishment of Cost Basis on Purchase of Facility as Ongoing Operation.

In establishing the cost basis for a facility purchased as an ongoing operation after July 1, 1971, the price paid by the purchaser shall be the cost basis where the purchaser can demonstrate that the sale was a bona fide sale and the price paid did not exceed the fair market value of the facility at the time of sale. The cost basis for depreciation purposes pursuant to this Agreement shall not exceed the undepreciated value calculated for Blue Cross purposes of those assets at the time of sale. If a transaction is demonstrated to be other than a bona

fide sale, the purchaser's depreciable basis shall be the lesser of the seller's cost basis or the undepreciated value calculated for Blue Cross purposes of such assets at the time of sale.

1.2. Interest Expense.

Principle

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

1.2.1. Definitions.

(a) *Interest* is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term which is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(b) *Necessary* requires that the interest:

(i) Be incurred on a loan made to satisfy a financial need of the Provider. Loans which result in excess funds or investments shall not be considered necessary.

(ii) Be incurred on a loan for a purpose reasonably related to patient care.

(iii) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or the Provider's qualified pension fund shall not be used to reduce interest expense.

(c) *Proper* requires that interest:

(i) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; or

(ii) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the Provider's donor-restricted funds, the funded depreciation account or the Provider's qualified pension fund.

1.2.2. Borrower-Lender Relationship.

(a) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan and could thus be suggestive of an agreement on higher rates, interest or unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the Provider to related organizations of the Provider is not allowable.

(b) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to the Provider by related organizations made prior to July 1, 1966 is an allowable cost, provided, the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where

the general fund of a Provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, the interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the Provider's qualified pension fund, funded depreciation account or funds borrowed from the religious order responsible for the operation of the Provider.

(c) Where funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the Provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

(d) Allowable interest expense on the current indebtedness of the Provider will be adjusted to reflect the extent to which working capital needs attributable to Covered Services for Subscribers have been met by Blue Cross payments designed to provide reimbursement for services currently furnished to Subscribers.

1.3. Bad Debts, Charity, and Courtesy Allowances.

Principle

Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to deductibles and coinsurance amounts are reimbursable hereunder except with respect to those incurred by Subscribers who are covered by a Form 11 Subscription Agreement which may, subsequent to the effective date of this Agreement be made available by Blue Cross.

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1.3.1. Definitions.

(a) *Bad debts* are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services and are collectible in money in the relatively near future.

(b) *Charity allowances* are reductions in charges made by the Provider of services because of the indigence or medical indigence of the patient.

(c) *Courtesy allowances* are reductions in charges in the form of an allowance to physicians, clergy, members of religious orders and others as approved by the governing body of the Provider, for services received from the Provider. Employee fringe benefits, such as hospitalization and personal health programs, are not considered to be courtesy allowances.

(d) The *Form 11 Subscription Agreement* shall be a subscription agreement with a substantially greater coinsurance amount and/or deductible to be offered subsequent to the effective date of this Agreement which Blue Cross develops for Subscribers with the objective of having lower charges for such Subscription Agreement than those now offered, and that election of the new Subscription Agreement shall be on an optional basis.

1.3.2. Normal Accounting Treatment Reduction in Revenue.

Bad debts, charity and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing services. Such costs have already been incurred in the production of the services.

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1.3.3. Requirements of this Agreement.

Under this Agreement the costs of Covered Services furnished Subscribers are not to be borne by individuals not covered by Blue Cross, and conversely, costs of services provided for other than Subscribers are not to be borne by Blue Cross. Uncollected revenue related to services rendered to Subscribers generally means the Provider has not recovered the cost of services covered by that revenue. The failure of Subscribers to pay the deductible and coinsurance amounts can result in the related costs of Covered Services being borne by other than Subscribers. The costs attributable to deductibles and coinsurance amounts, except as to debts incurred by Subscribers receiving Covered Services under a Form 11 Subscription Agreement, which remain unpaid, are to be added to the Blue Cross share of allowable costs. Bad debts arising from other sources are not allowable costs.

1.3.4. Criteria for Allowable Bad Debts.

A bad debt must meet the following criteria to be allowable:

(a) The debt must be related to Covered Services and derived from deductible and coinsurance amounts;

(b) The Provider must be able to establish that reasonable collection efforts were made;

(c) The debt was actually uncollectible when claimed as worthless; and

(d) Sound business judgment established that there was no likelihood of recovery at any time in the future.

1.3.5. Charging of Bad Debts and Bad Debt Recoveries.

The amounts uncollectible from specific Subscribers are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In

some cases an amount previously written off as a bad debt and allocated to Blue Cross may be recovered in a subsequent accounting period, in such cases the income therefrom must be used to reduce the cost of Subscriber Covered Services for the period in which the collection is made.

1.3.6. Charity Allowances.

Charity allowances have no relationship to Subscribers and are not allowable costs. The cost to the Provider of employee fringe-benefit programs is an allowable element of reimbursement.

1.4. Cost of Educational Activities.

Principle

An appropriate part of the net cost of approved educational activities is an allowable cost.

1.4.1. Definitions.

(a) *Approved educational activities* means formally organized or planned programs of study usually engaged in by the Provider in order to enhance the quality of patient care at an institution. These activities must be licensed where required by state law. Where licensing is not required, the institution must receive approval from the recognized national professional organizations for the particular activity.

(b) The *net cost* means the cost of approved educational activities (including stipends of trainees, compensation of teachers and other costs) less any reimbursements from grants, tuition, fellowships and other specific donations.

(c) *Appropriate part* means the net cost of the approved activity apportioned in accordance with the method set forth in this Exhibit A, Part I.

1.4.2. Educational Activities.

Many Providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community, however, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, Blue Cross will participate appropriately in the support of these activities. Although the intent of Blue Cross is to share in the support of educational activities customarily or traditionally carried on by Providers in conjunction with their operations, it is not intended that Blue Cross should participate in increased costs resulting from distribution, transfer or redistribution of costs from educational institutions or units.

1.4.3. "Orientation" and "On-the-Job Training."

The cost of orientation and on-the-job training are not within the scope of this subsection but are recognized as normal operating costs in accordance with the subsections relating thereto.

1.4.4. Approved Programs.

In addition to approved medical, osteopathic, and dental internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by Provider institutions, and their approving bodies, include the following:

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Program	*Approving Bodies*
(a) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(b) Dietetic interships ..	The American Dietetic Association.
(c) Hospital administration residencies ..	Members of the Association of University Programs in Hospital Administration.
(d) Inhalation therapy..	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(e) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(f) Medical technology .	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(g) Nurse anesthetists ..	The American Association of Nurse Anesthetists.

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Program	*Approving Bodies*
(h) Professional nursing	Approved by the respective state approving authorities. Reported for the United States by the National League for Nursing.
(i) Practical nursing ..	Approved by the respective state approving authorities. Reported for the United States by the National League for Nursing.
(j) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(k) Pharmacy residencies	American Society of Hospital Pharmacists.
(l) Physical therapy ...	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(m) X-ray technology ...	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

1.4.5. Other Educational Programs.

There may also be other educational programs not included in the foregoing in which the Provider is engaged. Appropriate consideration will be given by Blue Cross to the costs incurred for those activities that come within the purview of this subsection when determining allowable costs for apportionment under this Agreement.

1.4.6. Joint Study.

A joint study shall be undertaken at the onset of this Agreement by independent consultants acceptable to those Providers which are signatories hereto, or their nominee, and Blue Cross in order to establish standards which can be used to determine the number of interns and residents as well as the salary, fringe benefits, and other costs including those of the Director of Medical Education and other physicians participating in their teaching programs which are necessary for the maintenance of high quality care in the various categories of hospitals. The standards so determined shall be implemented as promptly as possible by the Provider (within the contractual limitations already established with interns, residents and other personnel) and any such personnel then in excess of such established standards shall be considered to be for purely educational purposes unrelated to patient care and the cost therefor shall not be reimbursable under this Agreement.

1.4.7. Limitation.

If Provider had a net per diem cost attributable to interns and residents (such cost shall include the salaries and special perquisites not provided other employees, the salary and cost of the Director of Medical Education, and the costs associated with other physicians

engaged either full or part time in education of residents and interns, but excluding malpractice insurance) in excess of three dollars and fifty cents ($3.50) per patient day in 1970-1971, the reimbursement to be provided hereunder shall be limited during the fiscal year 1971-1972 to one hundred twelve percent (112%) of costs attributable to interns and residents for the fiscal year 1970-1971, and during the fiscal year 1972-1973 to one hundred and seven percent (107%) of the fiscal 1971-1972 allowable cost. The foregoing limitation is separate and apart from any other limitation or reimbursement contained herein.

1.5. Research Costs.

Principle

Identifiable costs incurred directly or indirectly for research purposes which exceed normal costs of usual patient care and are not otherwise reimbursed, shall be excluded from allowable cost.

Application

(a) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs.

(b) To ensure that all identifiable costs associated either directly or indirectly with research are not included in computing reimbursable cost, Provider shall maintain detailed books of account and other records as are necessary to identify research costs.

(c) Normal and usual costs of patient care which are not reimbursed from other sources shall be included as an allowable cost when incurred directly or indirectly for research purposes.

1.6. Grants, Gifts and Income From Endowments.

Principle

Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.

1.6.1. Definitions.

(a) *Unrestricted grants, gifts and income from endowments* are funds, cash or otherwise, given to the Provider without restriction by the donor as to their use.

(b) *Designated or restricted grants, gifts and income from endowments* are funds, cash or otherwise which must be used only for specific purposes designated by the donor, but does not refer to unrestricted grants, gifts or income from endowments which have been restricted for a specific purpose by the Provider.

1.6.2. Application.

(a) Unrestricted funds, cash or otherwise, are generally the property of the Provider to be used in any manner its managment deems appropriate and should not be deducted from operating costs. It would be inequitable to require the Provider to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs which are not otherwise recoverable.

(b) Donor-restricted funds which are designated for paying certain operating expenses of the Provider should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the Provider would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restr ted contributions as well as from patient and third-party payers including Blue Cross.

1.7. Value of Services of Nonpaid Workers.

Principle

The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and the Provider for the performance of such services without direct remuneration from the Provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in this subsection. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses and paid no later than the end of the Provider's fiscal year following the fiscal year during which the services were rendered.

1.7.1. Limitations; Services of Nonpaid Workers.

To be reimbursable, the services of nonpaid workers must be performed on a regular, scheduled basis in positions customarily held by full-time employees and be necessary to enable the Provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which Pro-

viders generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under this Agreement. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a Provider canteen, cafeteria or gift shop, would not be reimbursable.

1.7.2. Application.

The following illustrates how the Provider would determine an amount to be allowed under this subsection. The prevailing salary for a lay nurse working in hospital A is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $2,000 and are included in the hospital's allowable operating costs. The hospital would then include in its records an additional $3,000 to bring the value of the services rendered to $5,000. The amount of $3,000 would be allowable where the Provider assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the Provider for the services.

1.8. Purchase Discounts, Allowances and Refunds of Expenses.

Principle

Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

1.8.1. Definitions.

(a) *Discounts* are generally reductions granted for the settlement of debts.

(b) *Allowances* are deductions granted for damage, delay, shortage, imperfection or other causes, excluding discounts and returns.

(c) *Refunds* are amounts paid back or a credit allowed on account of an overcollection.

1.8.2. Normal accounting treatment: reduction of costs.

All discounts, allowances and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period they will reduce the comparable purchases or expenses in the period in which they are received.

1.8.3. Application.

(a) Purchase discounts have been classified as cash, trade or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income, however, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are therefore reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them.

Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(b) As with discounts, allowances and rebates received from purchases of goods or services, refunds or previous expense payments are clearly reductions in cost and must be reflected in the determination of allowable costs. This treatment is equitable and in accord with that generally followed by governmental programs and other third-party organizations paying on the basis of cost.

1.9. Cost of Related Organizations.

Principle

Costs applicable to services, facilities and supplies furnished to the Provider by organizations related to the Provider by common ownership or control are includable in the allowable cost of the Provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere.

1.9.1. Definitions.

(a) *Related to the Provider* means that the Provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities or supplies, provided, however, cooperative organizations sponsored by three or more Providers shall not be deemed "related to the Provider."

(b) *Common ownership* exists when an individual or individuals possess significant ownership or equity in the Provider and the institution or organization serving the Provider.

(c) *Control* exists where an individual or an organization has the power, directly or indirectly, significantly

to influence or direct the actions or policies of an organization or institution.

1.9.2. Application.

(a) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance and other ways.

(b) Where the Provider obtains items of services, facilities or supplies from an organization even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the Provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities or supplies is lower than the cost to the supplier, the allowable cost to the Provider shall not exceed the market price.

1.9.3. Exception.

An exception is provided to this general principle if the Provider demonstrates by convincing evidence to the satisfaction of Blue Cross that (i) the supplying organization is a bona fide separate organization; (ii) a substantial part of its business activity of the type carried on with the Provider is transacted with others than the Provider and organizations related to the supplier by

common ownership or control and there is an open, competitive market for the type of services, facilities or supplies furnished by the organization; (iii) the services, facilities or supplies are those which commonly are obtained by institutions such as the Provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and (iv) the charge to the Provider is in line with the charge for such services, facilities or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities or supplies. In such cases, the charge by the supplier to the Provider for such services, facilities or supplies shall be an allowable cost.

Section 2. GENERAL PRINCIPLES OF REIMBURSEMENT.

2.1. Cost Related to Patient Care.

Principle

All payments to Providers of services must be based on the "reasonable cost" of services covered and related to the care of Subscribers except to Providers which charge on an overall hospital basis less than cost for Covered Services or which elect to be reimbursed for outpatient Covered Services under any of the options provided in subsection 2.4 of this Exhibit A, Part I. Reasonable cost includes all necessary and proper cost incurred in rendering the services, subject to principles relating to specific items of revenue and cost. Any Provider cost for Covered Services which would have been attributable to Part B of Medicare if the case had been covered under Medicare, shall be included.

2.1.1. Definitions.

(a) The *reasonable cost* of services is defined as that cost which is allowable under this Agreement. The cost of any services must be determined in accordance with regulations establishing the method to be used and the items to be included. The regulations in this subsection take into account both direct and indirect costs of the Provider. The objective of this subsection is to ensure that reasonable costs associated with Subscriber Covered Services will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by Blue Cross. These regulations also provide for the making of suitable retroactive adjustments after the Provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the Provider during the year for Covered Services from both Blue Cross and Subscribers and the amount determined in accordance with an accepted method of cost apportionment to be the actual allowable cost of Covered Services rendered to Subscribers during such year.

(b) *Necessary and proper costs* are costs which are appropriate and allowable in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the Provider's activity.

(c) *Allowable costs* are those inpatient per diem costs as determined hereunder subject to the limitations set forth in subsection 18.4 of the Agreement and subsection 1.4 of this Exhibit A, Part I.

The above limitations are subject to appropriate revision if major unanticipated changes occur which are beyond the control of either the Provider or Blue Cross as provided in subsection 18.4.3 of the Agreement.

2.1.2. Application.

(a) It is the intent of this Agreement that payments to the Provider should be fair and equitable to both the Provider and Blue Cross.

(b) The costs of Providers of services vary from one Provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision for payment of reasonable cost of Covered Services is intended to meet the actual costs, however widely they may vary from one institution to another.

(c) The determination of reasonable cost of Covered Services must be based on costs related to the care of Subscribers. Reasonable cost includes all necessary and proper expense incurred in rendering Covered Services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the Provider's operating costs include amounts not related to patient care, or specifically not reimbursable under the Subscription Agreement, such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the Provider will be reimbursed the actual costs of providing quality care however widely the actual costs may vary from Provider to Provider and from time to time for the same Provider.

(d) Notwithstanding subparagraphs (b) and (c) above, in determining the reasonableness of (i) budgeted expenses, (ii) gross inpatient per diem rates of interim payments by Blue Cross to Provider under subsection 18.1 of the Agreement, and (iii) costs exceeding the budgeted costs for reasons not covered by subsections 18.4.2, 18.4.3 or 18.4.4 of the Agreement, but for no other purpose, Blue Cross may reduce the proposed rate of interim payments or the final payment pursuant to subsection 2.4.5(b) of this Exhibit A, Part I, as appropriate, if Provider's costs, adjusted to remove any adverse variable produced by the rate of occupancy, are substantially higher than the costs of other hospitals in the same area which are similar in size, scope of services, utilization and other relevant factors. "Utilization" for this purpose refers not to Provider's occupancy rate but rather to the manner in which Provider is used as determined by the characteristics of the patients treated (i.e. its patient mix —age of patients, type of illness, etc.). If Blue Cross reduces Provider's payments pursuant to this subpart (d), Blue Cross shall have the burden of proving that the other hospitals, with the costs of which it compared the costs of Provider, have the similarity required hereby to a greater extent than any other area hospitals. All costs payable pursuant to Section 10 of the Agreement shall be considered in all comparisons made.

2.2. Determination of Cost of Covered Services to Blue Cross Subscribers.

Principle

Total allowable costs of a Provider shall be apportioned between Blue Cross Subscribers and other patients so that the share borne by Blue Cross is based upon actual Covered Services received by Subscribers. To accomplish this apportionment, the Provider shall use the departmental method for cost determination unless an alternative method is approved by the Provider and Blue Cross.

2.2.1. Definitions.

(a) Under the *departmental method* the ratio of Subscriber charges for Covered Services to total patient

charges for the services of each department is applied to the cost of that department.

(b) *Apportionment* means an allocation or distribution of allowable cost between Subscribers and other patients.

(c) *Routine services* means the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made.

(d) *Ancillary services* or special services are the services for which charges are customarily made in addition to routine services.

(e) *Charges* refers to the regular rates for various services which are charged to both Subscribers and other patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services and such charges shall be the same for all classes of patients.

(f) *Cost* refers to reasonable cost as described in subsection 2.1 hereof.

(g) The *ratio of Suscriber charges for Covered Services to total charges on a departmental basis,* as applied to inpatients, means the ratio of inpatient charges to Subscribers covered for services of a revenue-producing department or center to the inpatient charges of all patients for that center during an accounting period. After each revenue-producing center's ratio is determined the cost of Covered Services rendered to Subscribers is computed by applying the individual ratio for the center to the cost of the related center for the period.

2.2.2. Application.

(a) This Agreement provides that the costs of Covered Services with respect to individuals covered by Blue Cross will not be borne by individuals not so covered, and conversely, that costs with respect to individuals who are not covered by Blue Cross will not be borne by Blue Cross.

(b) The cost of Covered Services to Subscribers is to be determined by the Provider using the Departmental Method; the objective of which is to approximate as closely as practicable the actual cost of services rendered.

(c) The method of apportionment for use in determining the cost of Covered Services rendered to Subscribers has as its goal the allocation of total allowable costs between Subscribers and other patients in as equitable a manner as possible. If it is found that Subscribers receive more than the average amount of services, the Provider would receive reimbursement greater than average costs for all patients. Conversely, if Subscribers receive less than the average amount of services, the Provider would be reimbursed accordingly for the services rendered.

2.3. Adequate Cost Data and Cost Finding.

Principle

Providers receiving payment on the basis of reasonable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of account-

ing wil be acceptable, subject to appropriate treatment of capital expenditures.

2.3.1. Definitions.

(a) *Cost finding* is the process of recasting the data derived from the accounts ordinarily kept by a Provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(b) Under the *accrual basis of accounting* revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

2.3.2. Adequacy of Cost Information.

Adequate cost information must be obtained from the Provider's records to support payments made for services rendered to Subscribers. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts, and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

2.3.3. Uniform Accounting Procedures.

Implicit in providing adequate cost information is uniformity in reporting among all hospitals under this Agreement and therefore the Provider shall comply with the instructions to be issued from time to time to accomplish this as agreed to among Blue Cross and the hospitals under this Agreement.

2.3.4. Inadequate Data.

If the Provider is unable to provide adequate data, Blue Cross and the Provider will make an appropriate estimate for use in support of payments to be made for Covered Services rendered to Subscribers.

2.3.5. Cost Finding Methods.

After the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual costs of services rendered during that period.

(a) *Step-down method.* This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received

some service from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(b) *Other methods*—(i) *Double-apportionment method.* The double-apportionment method may be used by the Provider upon approval of Blue Cross. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as the revenue-producing centers. A preliminary allocation of the costs of the nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing centers directly to the revenue-producing centers. However, having elected to use the double-apportionment method, the Provider may not thereafter use the step-down method without approval of Blue Cross.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the Provider upon approval of Blue Cross. Request for the approval of such methods must be made on a prospective basis and submitted before the end of the first month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the Provider may not thereafter use either the

double-apportionment or step-down methods without similar request and approval.

2.3.6. Accounting Basis.

The cost data submitted hereunder must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

2.4. Payments to Providers.

Principle

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers except for the options to receive payments for Covered Services provided to outpatients at a percentage of charges. Interim payments approximating the actual costs of the Provider will be made on the most expeditious basis administratively feasible but not less often than semi-monthly. A retroactive adjustment based on actual costs will be made at the end of the reporting period. At the request of the Provider, payment will be made on the basis designed to reimburse currently for Covered Services rendered to Subscribers.

2.4.1. Amount and Frequency of Payment.

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers. Since actual costs of Covered Services cannot be determined until the end of the accounting period, the Provider must be paid on an estimated cost basis during the year. Interim payments shall be made no less often then semi-monthly, and Blue Cross will make payments on the most expeditious

basis administratively feasible. The estimated cost basis for determining interim payments during the year shall be based on one hundred percent of the Provider's budget submitted in accordance with Section 18 of this Agreement, as approved by Blue Cross, so that the retroactive adjustment based on actual costs will be as small as possible.

2.4.2. Optional Methods of Reimbursement for Covered Services Provided to Outpatients.

In lieu of receiving payments on the basis of reasonable costs as herein provided for Covered Services furnished to outpatients, the Provider may elect to receive payments for such services on the basis of either eighty or ninety percent of charges less d[illegible]e, or co-payment amounts, if any. If the Provider elects the ninety percent method, the payments to be made by Blue Cross will be subject to the limitation that increases in Provider's outpatient charges shall be limited to an increase not to exceed the percentage increase in total allowable cost applicable to the same fiscal year. The Provider shall make the foregoing election by submitting to Blue Cross in writing a document indicating which option it desires within fifteen days subsequent to the date Provider executes this Agreement for the fiscal year 1971-1972, and for the fiscal year 1972-1973, within sixty days after the beginning of such year. In the event the Provider shall make such election for either or both fiscal years, the retrocative adjustments hereinafter set forth in the subsection 2.4 hereof shall not apply for the fiscal year or years for which such election is made.

2.4.3. Interim Payments.

The gross interim inpatient per diem rates of payment will be determined based on the Provider's approved budget as submitted in accordance with subsection 18.2 of the Agreement. This interim rate of payment may be adjusted by Blue Cross during an accounting period if the Provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate within the limitations and exceptions set forth in subsection 18.4 of the Agreement. Likewise, Blue Cross may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

2.4.4. Determination of Interim Payments to Providers.

(a) Inpatient interim rates of payment will be a gross per diem cost including the total reasonable cost of all services, both covered and non-covered, to Subscribers. This gross per diem cost will then be adjusted by multiplying it by the percentage that charges for Covered Services (including deductibles and coinsurance amounts) are to total charges for all services on a per case basis. Deductible and coinsurance amounts, as well as the ward differential, if any, will then be deducted to determine the final interim payment for that individual Subscriber's case.

Example: On a six day stay under the Co-Pay Comprehensive Subscription Agreement with the following, arbitrarily chosen amounts, the remittance would be calculated as follows:

Gross Per Diem cost	$ 60.00
Total Charge to Subscriber	400.00
Charges for Blue Cross Covered Services (same as Blue Cross Allowance)	390.00
6 days × $60.00 Gross Per Diem Cost	360.00

Multiplied By:

$\frac{\$390.00 \text{ (Charges for Covered Services)}}{\$400.00 \text{ (Total Charges)}}$ 351.00

Less:

Co-Payment: 6 days at $5.00 per day .. 30.00

Ward Differential 0

Remittance to Provider $321.00

(b) Outpatient interim rates, except when Provider has elected an optional method of reimbursement, will be a percentage of charges based on outpatient cost and charge information of the Provider and calculated using the Provider's budget as submitted in accordance with subsection 18.2 of the Agreement to approximate cost as nearly as possible.

2.4.5. Retroactive Adjustment.

(a) The Provider shall be paid amounts determined to be due, but not less often than semi-monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of approved budgeted costs. Actual reasonable costs reimbursable to a Provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the Provider during the period into agreement with the reimbursable amount payable to the Provider for the Covered Services rendered to Subscribers during that period.

(b) In order to reimburse the Provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received and the desk review completed. For this purpose, the cost will be accepted as

reported—unless there are obvious errors or inconsistencies—subject to later audit. The amount determined as a result of the desk review shall be payable in full within thirty days following such review to either the Provider or Blue Cross, as appropriate. When an audit is made and the final liability of Blue Cross is determined, a final adjustment will be made.

(c) To determine the retroactive adjustment, the amount of the Provider's total allowable reasonable cost apportioned to Blue Cross for the reporting year is computed. This is the total amount of cost reimbursement the Provider is due to receive from Blue Cross and Subscribers for Covered Services rendered during the reporting period. The total of the interim payments made by Blue Cross in the reporting year and the deductibles and coinsurance amounts receivable from Subscribers is next computed. The difference between the reimbursement due and the sum of payments made by Blue Cross and amounts payable by Subscribers is the amount of the retroactive adjustment.

2.4.6. Payments to Hospitals which Charge Less than Cost.

Payments to hospitals which on an overall hospital basis charge less than cost for inpatient covered services will be based on charges and related to the percentage of total Blue Cross inpatient days in such institutions in the following manner:

If less than ten percent of the total Blue Cross inpatient days occur in hospitals which charge less than cost, payment to such hospitals shall be one hundred percent of charges for Covered Services. For each five percent increase in the percentage of total Blue Cross inpatient days which occur in hospitals which charge less than cost, in excess of the first ten percent, the percent of

charges paid to such hospitals shall be decreased one percent. The payment to such hospitals, however, shall never be less than ninety-five percent of charges.

2.4.7. Provision for Current Financing.

In addition to the basic procedure for payment to the Provider following the submission of bills to Blue Cross, payment will be made upon request by the Provider on a basis designed to reimburse currently for Covered Services furnished to Subscribers. The amount of such payment will be computed by Blue Cross and periodically adjusted to represent the average level of Covered Services unreimbursed by the basic payment procedure.

2.4.8. Cost Reporting Period.

For cost reporting purposes, Blue Cross will require submission of reports of operations based upon the Provider's accounting year within one hundred and twenty days of the close of the Provider's fiscal year.

PART II. PROSPECTIVE RATE BASIS.

If the Provider elects to be reimbursed on a prospective rate basis, it shall submit to Blue Cross the material required for budgetary review as provided in subsection 18.1 of the Agreement. Using this material and other data which it may request, Blue Cross and the Provider shall establish a gross prospective per diem rate, which shall be based on the principles set forth in Part I of this Exhibit A.

1. Inpatient Services.

The provider shall be reimbursed for inpatient Covered Services provided to Subscribers based on a gross prospective per diem rate which shall be determined

to the mutual satisfaction of Provider and Blue Cross in accordance with the terms and limitations set forth in this Agreement. In the event Provider is reimbursed for inpatient Covered Services in accordance with this Part II, those principles set forth in Part I of this Exhibit A which apply to reimbursement for inpatient services shall not alter or modify such fixed prospective rate, but the computation of inpatient claims shall be made in the manner as provided in subsection 2.4.4 "Determination of Interim Payment to Providers" of Part I of this Exhibit A, and such payments shall be final payment. No retroactive adjustment to such payments shall be made on the basis of actual cost except as otherwise provided in subsection 18.5 of this Agreement.

2. Outpatient Services.

In determining the payments for outpatient services to be made to a Provider who has elected to be reimbursed on a prospective rate basis, the Provider shall elect at the time such prospective rate is established which of the options available under subsection 2.4 of Part I of this Exhibit A it desires. The foregoing election shall be binding upon the Provider for the fiscal year covered by such prospective rate, but may be changed when a new prospective rate is established for a subsequent fiscal year.

3. Other Requirements.

Providers electing to be reimbursed on the prospective rate basis shall be subject to all the provisions in this Agreement except where specifically stated otherwise in this Part II of this Exhibit A or elsewhere in this Agreement.

EXHIBIT B

OPERATING BUDGET

INSTRUCTIONS

Introduction

The budget forms were prepared by the Joint Blue Cross-Hospital Council Task Force on Budget Review.

The form and content includes the information necessary for conformity with the new Blue Cross "Hospital Agreement" under provision section 18 "Budgetary Review Procedure."

Section 18. Budgetary Review Procedures.

18.1. Submission of Budgets.

Provider shall submit its annual budget to Blue Cross at least forty-five days prior to the first day of Provider's fiscal year on the standard form which is attached hereto as Exhibit B, as such may be modified from time to time. The budget shall include a proposed gross inpatient per diem rate for interim payments by Blue Cross to Provider. The budget as submitted to Blue Cross shall have had the prior approval of Provider's Budgetary Committee or similar financial committee, the membership of which shall include at least one member of Provider's governing body. For Provider's first fiscal year under this Agreement, the foregoing requirement may be satisfied by submission of Provider's budget in its own format with comparative information in such reasonable detail as is necessary to distinguish inpatient and outpatient costs, determine the effects of any wage-price stabilization policies on anticipated costs in the budgeted year, and permit line comparisons with previous years' budgets and financial results of operations as soon as reasonably possible

after the execution of this Agreement, but in no event later than 30 days after the execution hereof. The budgets submitted in accordance with this subsection 18.1 shall include all adjustments made necessary by the application of federal price stabilization requirements.

18.2. Interim Payments.

Blue Cross shall review the data submitted by Provider to determine the reasonableness of the expenses included therein in accordance with the provisions contained in Exhibit A hereof utilizing the following procedures:

18.2.1. If Blue Cross shall determine that the estimates set forth in the budget submitted by the Provider are reasonable within the meaning of subsection 2.1 of Exhibit A, Part I hereof, Blue Cross shall so advise the Provider and use the gross inpatient interim per diem rate proposed by Provider for admissions during such budgeted fiscal year.

18.2.2. If Blue Cross determines that the cost estimates included in Provider's budget as submitted are unreasonable, or that the gross inpatient interim per diem rate proposed by Provider has not been properly computed, Blue Cross shall within forty-five days of its receipt of said budget so advise Provider and request a meeting with Provider's representatives to review the matter and determine whether appropriate modifications should be made in the budget or the gross inpatient interim per diem rate. If Blue Cross does not so advise Provider within the aforesaid forty-five day period, Blue Cross shall reimburse Provider based on the gross inpatient interim per diem rate proposed by Provider until such time as a meeting can be held to review the reasonableness of Provider's budget.

Exhibit 17

18.2.3. If Provider and Blue Cross are unable to reach agreement as to the reasonableness of the budgeted costs, Blue Cross shall determine the gross inpatient interim per diem rates for the budgeted year based upon its review and findings, considering any supplemental data submitted by Provider. In such event, Provider may exercise its right of appeal as set forth in Section 21 hereof, accepting the interim rate set by Blue Cross until a final decision is rendered by the Appeals Board or Court, as appropriate. However, it is expressly understood by the parties hereto that the foregoing right of appeal shall pertain only to gross inpatient interim per diem rates as determined above and does not extend to any rate fixed pursuant to subsection 18.5.

18.2.4. When the gross inpatient interim per diem rates have been based on unaudited data, such rates shall be subject to appropriate increase or decrease retroactively and prospectively if the net audit adjustments, excluding non-recurring items, amount in aggregate to more than one dollar ($1.00) per patient day subject to the limitations contained in subsection 18.4.

18.2.5. All gross inpatient interim per diem rates established pursuant to this Agreement shall be subject to review and adjustment in the event a major unforeseeable and unanticipated cost increase or decrease occurs during the fiscal year, in which case the Provider shall so advise Blue Cross promptly of such changes and forward to Blue Cross the appropriate supporting data.

Statistical definitions shall conform to the A.H.A. Uniform Hospital Definitions dated 1960.

Providers are required to enter their name, Blue Cross Code Number and the applicable dates on each page in the spaces provided, also enter applicable dates in the headings, "Actual, Projected and Budget."

Exhibit 17

Budget Forms

A. Summary of Costs
B. Calculation of Tentative Blue Cross Gross Payment Rate
C. Departmental Summary and Per Diem Calculation
D. Statistics
E. Salaries & Wages-Employees & Fees
F. Supplies & Expenses
G. Depreciation Expense
H. Analysis of Recovery of Expense Items
I. Personnel Policies
J. Supplemental Questionnaire
K. Comparative Report Educational Expenses

Filing Date

Budget forms should be prepared and submitted forty-five days (45) days prior to the beginning of the fiscal year.

Number of Copies Required

All forms should be completed and filed in *duplicate*. (Typing not required, but must be legible copy.)

Actual Expenses

Should represent actual expenses for the first complete preceding fiscal year.

Projected Expenses

Provider should indicate the number of months of actual expenses (minimum of six months) and the number of months of estimated expenses in the current fiscal year.

Exhibit 17

Instructions for Completing Budget Forms

Form A—Self-explanatory.

Form B—Self-explanatory.

Form C—Departmental Summary and Per Diem Calculation:

(1) Detailed figures reported should be budgeted figures only.

(2) Amounts reported as Salaries & Wages-Employees & Fees, and Supplies & Expenses should agree in total with the amounts reported on the budgeted detailed expense schedules (Forms E, F, and G).

(3) The per diem amounts should be based on the total budgeted patient days as reported on Form D.

(4) The paid hours should agree with the total of hours as reported on the detailed Form E.

(5) The requested operating statistics should be completed in accordance with the detailed notes on Form C, Page 5 and should be based on the amounts and hours as reported on Form C.

Form D—The regularly maintained number of beds represents the *average* number of beds available, set up and staffed for use during the applicable year.

Form E—Salaries & Wages-Employees & Fees:

(1) The number of full-time equivalent employees (FTE) should be determined by dividing the paid hours by 2080 annual hours per employee.

Exhibit 17

The number of salaried employees, and/or physicians on a fee basis for which paid hours are not recorded shall be included in the FTE, calculated by adding 2080 hours for each such full-time person and the part of 2080 hours represented by the percent of time spent in hospital activities for each such part-time person.

(2) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(3) The total amount on Page 7, Line 93 should be carried forward to Form A, Line 1.

Form F—Supplies & Expenses:

(1) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(2) The total amount on Page 7, Line 91 should be carried forward to Form A, Line 2.

(3) The total amount of interest expense on Page 7, Line 94 should be carried forward to Form A, Line 4.

Form G—Depreciation Expense:

(1) For Blue Cross purposes, only straight line method of depreciation is permitted.

(2) The total amount of depreciation on Form G, Line 9 should be carried forward to Form A, Line 3.

Exhibit 17

Form H—Analysis of Recovery of Expense Items:

(1) The totals on Form H, Line 16 should be carried forward to Form A, Line 6.

Form I—Self-explanatory.

Form J—Self-explanatory.

Form K—Comparative Report Educational Expenses:

The purpose of this Form is to determine the amount of educational expense allowable for reimbursement purposes within the limitations set forth in the "Hospital Agreement."

(1) Salaries and fees are the totals including those charged directly to the teaching program, to various cost centers, etc. Portions of salaries and fees paid to those individuals which are not related to intern and residence programs are to be excluded.

(2) Fringes and/or perquisites are those which are *not* furnished all other employees; e.g. value of living accommodations, meals, laundry, drugs, use of automobile, etc., but excluding malpractice insurance.

FORM A

Date Submitted: _____

B. C. Code No. _____

Percentage Variances Budget vs.		
Actual	Projected	
%	%	

OPERATING BUDGET
Summary of Costs

_____ (HOSPITAL)

Fiscal Year: _____

TOTAL OPERATING EXPENSES:	ACTUAL Amount	ACTUAL %	PROJECTED Amount	PROJECTED %	BUDGET Amount	BUDGET %
1. Salaries & Wages—Employees & Fees (From Form E, line 93)	$		$		$	100%
2. Supplies & Expenses (From Form F, line 91)						
3. Depreciation (From Form G, line 9)						
4. Interest on Indebtedness (From Form F, line 94)						
5. TOTAL Expenses		100%		100%	$	100%
Less Deductions and Recoveries:						
6. Items of income which are recovery of expenses (From Form H, line 16)						
7. Less: Research (From Form E, line 91 plus Form F, line 75)						
8. Less: Non-Reimbursable Functions (From Form E, line 92 plus Form F, line 76)						
9. Less: Non-Allowable Educational Expense (From Form K, line 14)						
10. Less: Home Care (From Form E, line 69 plus Form F, line 52)						
11. Less: Extended Care (From Form E, line 39 plus Form F, line 51)						
12. Less: Other: (Explain)						
13.						
14. TOTAL Deductions	$		$		$	
15. TOTAL Patient Care Expenses Net	$		$		$	

I certify that this Budget has been reviewed and approved by the governing body of this institution.

_____ (Date) _____ (Signature) _____ (Title)

Exhibit B

OPERATING BUDGET
Calculation of Tentative Blue Cross Gross Payment Rate

FORM B 230a

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL	PROJECTED	BUDGET	Percentage Variances Budget VS. (Note 3) Actual	Percentage Variances Budget VS. (Note 3) Projected
1. Total Patient Care Expenses Net (Form A, line 15)	$	$	$	%	%
2. Less: Depreciation Expense (Form A, line 3)					
3. Total Patient Care Expenses Net-Less: Depreciation (Line 1 –line 2)					
4. Less: Out Patient Expenses (Note 1)	$	$	$		
5. Total Modified In Patient Expense (Line 3 –line 4)					
6. Total In Patient Days (Excluding Newborn)					
7. Average Per Diem Modified In Patient Expense (Line 5 ÷ line 6)					
8. In Patient Portion of Depreciation Expense (Note 2)	$	$	$		
9.					
10. Average Per Diem Depreciation In Patient Expense (Line 8 ÷ line 6)					
11. TOTAL Average Per Diem In Patient Expenses (Line 7 + line 10)	$	$	$		

Note 1—Out Patient expenses to be calculated on the ratio of the previous years out patient expenses to total expenses per Blue Cross Cost Report Schedule C applied to Line 3 above.

Note 2—Depreciation expenses to be calculated on the ratio of the previous years in patient expenses to total expenses per Blue Cross Cost Report Schedule C, applied to amount of depreciation expense in Line 2.

Note 3—Attach any necessary supplemental data required to explain percentage increase in excess of contract limitation.

Exhibit B

Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 1 of 5

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS: Salaries & Wages—Employees and Fees Amount	Salaries & Wages—Employees and Fees Per Diem	Supplies & Expenses (Forms F & G) Amount	Supplies & Expenses (Forms F & G) Per Diem	Budgeted Total Costs Amount	Budgeted Total Costs Per Diem	Paid Hours (Form E)	Operating Departmental Statistics
1. ADMINISTRATIVE AND GENERAL								
Executive offices	$	$	$	$	$	$		
Accounting & Fiscal								
All other Administrative Expenses								
TOTAL	$	$	$	$	$	$		
Direct Cost Per Bed (note 1)								
Manhours Per Bed (note 2)								
2. DIETARY								
Number of Meals Served								
Direct Cost Per Meal								
Meals Served Per Manhour								
3. PLANT								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								
4. HOUSEKEEPING								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								

Exhibit B

Exhibit 17

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OPERATING BUDGET
Departmental Summary and Per Diem Calculation

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
5 MAINTENANCE OF PERSONNEL	$	$	$	$	$	$		
6 LAUNDRY AND LINEN								
Laundry Direct Cost Per 100 lbs.								
Laundry lbs. Per Manhour								
Laundry lbs. Per Patient Day								
Laundry and Linen D. C. Per Bed (note 1)								
7 TOTAL NURSING SERVICE								
OB Manhours Per Bed Per Day (note 3)								
Med. Surg. Manhours Per Bed Per Day (note 3)								
All other Manhours Per Bed Per Day (note 3)								
TOTAL Nursing Manhours Per Bed Per Day (note 3)								
8 CENTRAL STERILE SUPPLY								
Direct Cost Per Bed (note 1)								
9 DELIVERY ROOM & POST PARTUM RECOVERY								
Number of Deliveries								
Direct Cost Per Delivery								
Manhours Per Delivery								
10 OPERATING ROOM & CYSTOSCOPY								
Number of Operations								
Direct Cost Per Operation								
Manhours Per Operation								

Exhibit B

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Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
11 RECOVERY ROOM	$	$	$	$	$	$		
12 LABORATORY								
13 BLOOD BANK								
14 X-RAY DEPT. INCLUDING X-RAY THERAPY, AND ISOTOPE THERAPY								
Manhours per procedure								
Direct cost per procedure								
15 PHARMACY								
16 MEDICAL RECORDS AND LIBRARY								
Direct cost per bed (note 1)								
Manhours per bed (note 2)								
17 ANESTHESIOLOGY								
18 INHALATION THERAPY								
19 EMERGENCY ROOM								
20 AMBULANCE SERVICE								
21 CLINICS								

Exhibit B

B-8

Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
22. ALL OTHER PROFESSIONAL SERVICES	$	$	$	$	$	$		
Physical Therapy								
Social Service								
Home Health Care								
Day Nursery								
Electrocardiograph								
Electroencephlagraph								
Medical Photography & Illustration								
Speech Therapy								
Occupational & Recreational Therapy								
Extended Care								
23. MEDICAL EDUCATION								
(should agree with Form K, line 13)								
24. PARA-MEDICAL EDUCATION								
School of Nursing (R.N.)								
Other Education								
Direct Cost Per Bed (note 1)								
25. RESEARCH EXPENSES								
26. NON-REIMBURSABLE FUNCTIONS								

Exhibit B

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Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
27. NON-DEPARTMENTAL EXPENSES	$	$	$	$	$	$		
Payroll Taxes								
Fire, Liability, Malpractice & Other Insurance								
Group Life								
Hospitalization								
Major Medical								
Workmens Compensation								
Unemployment Insurance								
Tuition Refund								
Pension Costs								
Taxes Other than Payroll								
Other								
Interest—Capital Debt								
Interest—Working Capital Debt								
Depreciation								
28. TOTAL (should agree with amounts reported on Forms E, F, & G)								

Note 1—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total budgeted costs.

Note 2—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total paid hours.

Note 3—This is a daily statistic and is calculated by multiplying the total number of regularly maintained beds by 365 days and dividing the result into the total paid hours.

Exhibit B

B-10

Exhibit 17

NOTE: Refer AHA Uniform Definitions (1960) for explanation of statistical terms.

OPERATING BUDGET
Statistics

FORM D
Page 1 of 3

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Date Submitted: _____

B. C. Code No. _____

_____
(HOSPITAL)

Fiscal Year: _____

	Number of Beds Regularly Maintained	Total Patient Admissions	Total Patient Days	Average Length Of Stay	Percent Occupancy
Actual ____					
Major Services:					
Medical—Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Projected ____ ____ Months Actual ____ Months Estimated					
Major Services:					
Medical—Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Budget ____					
Major Services:					
Medical—Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					

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Exhibit 17

Exhibit B

OPERATING BUDGET
Statistics

FORM D
Page 2 of 3

_____
(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Service	Total	Inpatients	%	Outpatients	%
Laboratory Operations					
Clinical Lab Test:					
Actual ____					
Projected ____					
Budget ____					
Pathological Exams:					
Actual ____					
Projected ____					
Budget ____					

B-12

Exhibit 17

Radiological Operations					
Diagnostic X-Ray Procedures					
Actual ____					
Projected ____					
Budget ____					
Therapeutic X-Ray Procedures					
Actual ____					
Projected ____					
Budget ____					
Radio-Isotope Procedures					
Actual ____					
Projected ____					
Budget ____					

237a

Exhibit B

238a

OPERATING BUDGET
Statistics

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Clinic Statistics	Number of Clinics Operated	Total Clinic Hours Scheduled Weekly	Number of Visits Annually	No. of Patients Treated Annually
Actual ____				
Projected ____				
Budget ____				

Private Ambulatory Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Emergency Room Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Number of Operations	Total Number
Actual ____	
Projected ____	
Budget ____	

Exhibit B

B-13

Exhibit 17

OPERATING BUDGET
Salaries & Wages—Employees & Fees

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____ _____

	____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
1. A. SERVICE DEPARTMENTS									
2. Administrative & General:									
3. Executive Offices									
4. Accounting and Fiscal Services									
5. All Other Administrative									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13. TOTAL Administrative & General									
14.									
15. Dietary (including Cafeteria)									
16.									

Exhibit B

B-14

Exhibit 17

279a

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
17.	PLANT:									
18.	Maintenance									
19.	Operation of Plant									
20.	Motor Service									
21.	Security									
22.	TOTAL Plant									
23.										
24.	Housekeeping									
25.	Maintenance of Personnel (Personnel Quarters)									
26.										
27.	Laundry									
28.	Linen, Bedding & Sewing Room									
29.	TOTAL Service Departments									

Exhibit B

Exhibit 17

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
30.	B. PROFESSIONAL CARE OF PATIENTS									
31.	Nursing Service:									
32.	Nursing Service Administration									
33.	Obstetrics									
34.	Medical and Surgical									
35.	Intensive Care & Coronary Care Units									
36.	Pediatrics									
37.	Nursery									
38.	Psychiatric									
39.	Extended Care									
40.										
41.										
42.	TOTAL Nursing Service									
43.										
44.	Central Sterile Supply									

Exhibit B

Exhibit 17

OPERATING BUDGET
Salaries & Wages—Employees & Fees

FORM E
Page 4 of 7

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
45.	Delivery Room & Post Partum Recovery									
46.	Operating Room & Cystoscopy									
47.	Recovery Room									
48.										
49.	Laboratories									
50.	Blood Bank									
51.	Medical Photography & Illustration									
52.	Diagnostic X-Ray									
53.	X-Ray Therapy									
54.										
55.	Radio—Isotopes									
56.	Renal Dialysis									
57.										
58.	Pharmacy									
59.	Medical Records									

B-17

Exhibit 17

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

FORM E
Page 5 of 7

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
60.	Medical Library									
61.	Anesthesiology									
62.	Inhalation Therapy									
63.	Electroencephlagraph									
64.	Electrocardiograph									
65.										
66.	Physical Therapy									
67.	Speech Therapy									
68.	Occupational & Recreational Therapy									
69.	Home Health Care									
70.	Social Service									
71.	Emergency Room									
72.	Clinics									
73.	Ambulance Service									

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Exhibit 17

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL			PROJECTED _____ Months Actual _____ Months Est.			BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
74.									
75.									
76.									
77.									
78.									
79. TOTAL Professional Services									
80. Medical Education (should agree with Form K, line 13)									
81.									
82. C. PARA-MEDICAL EDUCATION									
83. School of Nursing									
84. School of Practical Nursing									
85. In-Service Education									
86. School of Medical Technology									

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL			PROJECTED _____ Months Actual _____ Months Est.			BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
87. School of X-Ray Technology									
88.									
89.									
90. TOTAL Para-Medical Education									
91. Research									
92. Non Reimbursable Functions									
93. TOTAL Salary & Wages—Employees & Fees (To Form A, line 1)	$			$			$		

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 1 of 7

Date Submitted: _____

_____
(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
1. SERVICE DEPARTMENTS			
2. Executive			
3. Accounting & Fiscal			
4. All other Administrative			
5. TOTAL Administrative			
6. Dietary (including Cafeteria)			
7. Plant			
8. Housekeeping			
9. Maintenance of Personnel (Personnel Quarters)			
10. Laundry			
11. Linen, Bedding & Sewing Room			
12.			
13.			
14. TOTAL Service Departments			
15.			

Exhibit B

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Exhibit 17

246a

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 2 of 7

_____
(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
16. PROFESSIONAL CARE OF PATIENTS:			
17. Nursing Service			
18. Central Sterile Supply			
19. Delivery Room & Post Partum Recovery			
20. Operating Room & Cystoscopy			
21. Recovery Room			
22. Laboratories			
23. Blood Bank			
24. Medical Photography & Illustration			
25. Renal Dialysis			
26.			
27.			
28.			
29. Diagnostic X-Ray			
30. X-Ray Therapy			
31.			

Exhibit B

B-22

Exhibit 17

247a

248a

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
32. Radio—Isotopes			
33.			
34.			
35.			
36. Pharmacy			
37.			
38. Medical Library			
39. Medical Records			
40.			
41.			
42. Anesthesiology			
43. Inhalation Therapy			
44. Electroencephlagraph			
45. Electrocardiograph			
46.			

Exhibit 17

Exhibit B

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
47. Physical Therapy			
48. Speech Therapy			
49. Social Service			
50. Occupational and Recreational Therapy			
51. Extended Care			
52. Home Health Care			
53. Emergency Room			
54. Ambulance Service			
55. Clinics			
56.			
57.			
58.			
59.			
60.			
61.			

Exhibit 17

249a

ExHibit B

250a

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
62. Medical Education (should agree with Form K, line 13)			
63.			
64.			
65. TOTAL Professional Care of Patient Expenses			
66. PARA-MEDICAL EDUCATION:			
67. School of Nursing			
68. School of Practical Nursing			
69.			
70. In-Service Education			
71. School of Medical Technology			
72. School of X-Ray Technology			
73.			
74. TOTAL Para-Medical Education			
75. Research Expenses			

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Exhibit 17

Exhibit B

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
76. Non Reimbursable Functions			
TOTAL DEPARTMENTAL EXPENSES (Lines 1-76)			
NON-DEPARTMENTAL EXPENSES			
77. Payroll Taxes			
78. Fire, Liability, Malpractice & Other Insurance			
79. Group Life			
80. Hospitalization			
81. Major Medical			
82. Workmen's Compensation			
83. Unemployment Insurance			
84. Tuition Refund			
85. Pension Costs			
86. Taxes Other than Payroll			
87. Other			

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Exhibit 17

251a

Exhibit B

252a

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
88.			
89.			
90. TOTAL NON-DEPARTMENTAL EXPENSES			
91. TOTAL SUPPLIES & EXPENSES (To Form A, line 2)			
92. Interest Expense—Capital Indebtedness			
93. Interest Expense—Working Capital Indebtedness			
94. TOTAL INTEREST EXPENSE (To Form A, line 4)			

Note: Indicate Cost Center to which IV's are charged

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Exhibit 17

Exhibit B

OPERATING BUDGET
Depreciation Expense

FORM G

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

	____ ACTUAL		____ PROJECTED		BUDGET	
	Method	Amount	Method	Amount	Method	Amount
1. Land Improvements		$		$		$
2. Buildings						
3. Fixed Equipment						
4. Automobiles and Trucks						
5. Major Movable Equipment						
6. Leasehold Improvements						
7. Minor Equipment						
8. Other						
9. TOTAL (To Form A, Line 3)		$		$		$

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Exhibit 17

253a

Exhibit B

OPERATING BUDGET
Analysis of Recovery of Expense Items

FORM H

Date Submitted: _____

_____ (HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

ITEM	ACTUAL	PROJECTED	BUDGET
1. Telephone	$	$	$
2. Laundry Services			
3. Nurses', Guest' & Employees' Meals			
4. Rental of Quarters			
5. Income from Nurses' Training Schools			
6. Sales of Supplies (To Doctors & Employees)			
7. Rebates & Quantity Discounts			
8. Nurses' Registry Fees			
9. Medical Transcript Fees			
10. Other (List Below)			
11			
12			
13			
14			
15			
16. TOTAL (To Form A, line 6)	$	$	$

Exhibit B

OPERATING BUDGET
Personnel Policies

FORM I
Page 1 of 2

Date Submitted: _____

_____ (HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

1. Indicate the current minimum hiring wage your institution is paying for unskilled labor.

RATE $ _____

2. Are there any plans to increase the above minimum wage during the budgeted period, please explain below.

_____

_____

_____

_____

3. Indicate the beginning rate on July 1 of budgeted year for the following personnel classifications:

Interns	$	Annually
Residents		Annually
Registered Nurses		Annually
Licensed Practical Nurses		Annually
Nursing Aides		Hourly
Orderlies		Hourly

4. Does the hospital provide any housing for employees? Indicate type of housing, number of units, any income, etc.

_____

_____

5. On what date do your employees receive their annual merit adjustments, i.e., employment anniversary, July 1, other ?

_____

6. Outline briefly union contracts in force. Include names of unions, number of employees in each bargaining unit and expiration date of contracts.

_____

_____

_____

_____

Exhibit B

OPERATING BUDGET
Personnel Policies

FORM I
Page 2 of

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

7 Nursing Service Complement

	FTE	Percent
RN's		
LPN's		
Aides		
All Other Nursing Personnel		
TOTAL—Per Form E, line 42		100%

8 How many hours constitute the regular work week? _____

Briefly explain the following policies of your hospital, or submit a copy of your personnel policies

9 Premium Pay — Overtime _____
— On call pay
— Shift differential
— Call back Allowance

10 Number of holidays granted each year _____

11 Briefly explain vacation policy _____

12 Employee benefits (indicate whether contributory or non-contributory) _____

13 Sick leave benefits _____

Exhibit B

OPERATING BUDGET
Supplemental Questionnaire

FORM J
Page 1 of 2

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

1. Indicate by check those services or programs in which you participate:

	YES	NO
H.A.S. (Hospital Administrative Services)		
P.A.S. (Professional Activity Study)		
M.A.P. (Medical Audit Program)		
P.A.T. (Pre-Admission Testing)		
OB/GYN mixing		
H.U.P. (Hospital Utilization Program)		
S.P.U. (Short Procedure Unit)		
M.C.U. (Minimal Care Unit)		

2. Indicate status of prior years cost filings with third parties (not amounts due)

	Blue Cross	Medicare	Medicaid
1967			
1968			
1969			
1970			
1971			
1972			

3. Indicate any service contracts which the hospital has for the performance of Patient Care Services, Data Processing, Dietary, Housekeeping, Laundry, etc.

_____

Exhibit B

OPERATING BUDGET
Supplemental Questionnaire

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

4. Indicate any rentals and leases in excess of $5,000 per annum.

5. List any new facilities, programs, or services, since July 1, 1971. Indicate the approximate annual direct costs (salaries and supplies) included in the 197 budget for these programs or services and whether approval of an appropriate Planning Agency, if necessary, was obtained.

6. Do you have approved intern and residency programs ? ☐ yes ☐ no. If yes, please list below:

7. Please attach a copy of most recent audited Financial Statement.

8. List hospital based ancillary services which bill separately from hospital billing. _____

Exhibit B

FORM K

OPERATING BUDGET
Comparative Report Educational Expenses

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

PERSONNEL: Number F.T./P.T.	_____ ACTUAL				_____ PROJECTED				_____ BUDGET				Percentage Variance Budget vs.	
	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Actual	Proj.
1. Interns	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
2. Residents	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
3. Director Med. Ed.	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
4. Sec'y. & Clerks	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
5. Teaching M.D.'s	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
6. Others:	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
7. Total Expenses	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
EXPENSE OFFSETS 8. Grants	$													
9. Fellowships	$													
10. Income-Affiliates	$													
11. Others:	$													
12. Total Offsets	$													
13. Total Net Expenses	$													
14. Total Net Expenses in Excess of Contract Limitation (Attach Detailed Calculation) $														

Exhibit B

Exhibit 17

EXHIBIT C

HOSPITAL SAFETY PROGRAM

In accordance with Section 20 of this Agreement, the Provider agrees to establish a safety program incorporating, as practicable and appropriate, the following principles:

Section 1. Management Involvement.

(a) The basic program shall incorporate procedures designed to foster loss control and malpractice prevention, and shall be communicated in written form to key hospital personnel.

(b) Plans to implement the program and periodic progress reports shall be included on the agenda of top level management meetings.

(c) A Safety Committee shall be formed to include at least one trustee, administrative personnel, at least one physician, and other appropriate persons.

Section 2. Education.

(a) The Safety Committee shall review incidents threatening the safety of patients.

(b) The Provider shall instruct medical personnel as regards the nature and legal implications of malpractice.

Section 3. Policies and Standards for Reporting Incidents.

All incidents or unusual occurrences threatening the safety of patients shall be reported in writing to the chief administrative officer, or his designee, and the Safety Committee.

Exhibit 17

Section 4. Accident Investigation.

The chief administrative officer, or his designee, shall make prompt investigation of all non-medical incidents and the chief medical officer, or his designee, shall investigate all medical incidents. The Safety Committee shall take appropriate steps to prevent assertions of malpractice and develop appropriate policies to implement such practice.

Section 5. Facility Inspections.

The chief administrative officer, or his designee, shall inspect Provider's facilities regularly giving particular attention to equipment involved in critical patient care. All deficiencies or malfunctions shall be reported along with the corrective action taken. Medical personnel shall be designated to periodically inspect equipment involved in critical patient care.

Section 6. Supervisory Training.

Procedures shall be established for the training of not only supervisory personnel, but all employees shall be included in the safety program.

Section 7. Group Meetings.

Safety meetings shall be held periodically by each department of the Provider.

Section 8. Personnel Protection.

The Provider shall provide protective equipment to appropriate personnel and ensure that such is periodically inspected.

Exhibit 17

Section 9. Contract Review.

Purchasing arrangements, including arrangements for the purchase of drugs being used for experimental purposes, shall be carefully reviewed to ensure that suppliers have assumed responsibility for inherent defects in their products.

Section 10. Other Loss Control Programs.

Programs shall be established to control and eliminate fire hazards, workmen's compensation losses, liability losses and other types of avoidable expenses.

Exhibit 18

HOSPITAL AGREEMENT

July 1, 1971

Amendment Effective July 1, 1972

The parties hereto, intending to be legally bound hereby, agree that the Hospital Agreement dated July 1, 1971 to which they are parties (the "Agreement"), shall be amended as follows:

1. *Subsection 18.4.6 is deleted in its entirety and the following inserted in its place:*

18.4.6. Subject to the requirements set forth in subsections 18.2, 18.3 and 18.4 hereof and subsection 1.4 of Exhibit A, Part I, the maximum total allowable cost to be used as the basis for calculating the reimbursement to be paid Provider by Blue Cross for the fiscal year 1972-1973 shall be limited to the total actual allowable costs of Provider approved by Blue Cross for the fiscal year 1971-1972, plus such increase as may be permitted by the applicable limitations promulgated pursuant to the Economic Stabilization Act, as amended. Any such increase shall be permitted Provider if the item producing the increase is allowable as a reimbursable cost under the Agreement as amended hereby and is (i) specifically allowed upon review by the authorized regulatory body having appropriate jurisdiction over hospital price increases, or (ii) generally allowed hospitals without need for specific approval. In requesting any such increase, Provider agrees to furnish Blue Cross with all pertinent supporting data and to annualize such so that appropriate line comparisons may be made with the applicable prior fiscal years.

In the event public notice is given by the Federal government that the price controls imposed on Provider pursuant to the Economic Stabilization Act, as amended,

Exhibit 18

are to be abondoned, discontinued or otherwise terminated, Blue Cross and Provider, or its designee, shall meet within five business days after the date of such notice to negotiate an alternative maximum total allowable cost which shall be effective as of the date the aforesaid price controls were terminated. Unless agreement as to such alternative maximum total allowable cost be reached within thirty days immediately following the date of notice that the price controls imposed on Provider are to be terminated the Agreement shall terminate subject to Section 27 thereof provided, however, that the 90 day period set forth in Section 27 of the Agreement shall in such event be reduced to 60 days. The interim rates for the period following the date the price controls are discontinued or otherwise terminated shall be those interim rates which were in effect at the date of said termination until such later date as the Agreement is amended to reflect a negotiated alternative maximum total allowable cost.

2. *Except as amended hereby, the Agreement and all other provisions thereof shall remain in full force and effect, and the execution of this Amendment shall constitute execution of the Agreement as so amended, effective as of July 1, 1972.*

Exhibit 18

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have caused these presents to be executed by their proper officers as of the date of execution set forth below.

Date of Execution

_____

Effective Date

July 1, 1972

_____
Name of Provider

By _____
Signature

_____
Title of Signing Officer

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

Exhibit 19

BLUE CROSS OF GREATER PHILADELPHIA

1333 Chestnut Street, Philadelphia, Pennsylvania 19107

December 29, 1972

Mr. Clarence H. Warden, Jr., Chairman
Delaware Valley Hospital Council
311 South Juniper Street
Philadelphia, Pennsylvania 19107

Dear Clarence:

As we are all aware, the current "Hospital Agreement" automatically terminates on June 30, 1973. Although there is no specific date by which discussions on a replacement contract are required to start under the "Hospital Agreement", the previous contract specified six months prior to termination, and you alluded to the matter of negotiations during our most recent meeting on intern and resident cost.

We are most anxious that the new contract be complete, approved and in the hands of the hospitals before July 1, 1973 in order to avoid the impairment of the hospitals' cash flow, as it was last year.

We believe that our negotiations can be expedited if all parties study and evaluate those various items and concepts which might be considered for inclusion in the replacement contract and that we lay the groundwork for future discussions by a prompt preliminary informal exchange of our collective thoughts and suggestions. To this end we are enclosing a summary of the current Insurance Department's "Guidelines" [*see* Exhibit 15, *infra*], many of which have been incorporated in the present contract, and are listing below a few of our thoughts which we hope you will explore and comment on:

1. Utilization review does not seem to be controlling unnecessary hospitalization at all hospitals.

Exhibit 19

This includes not only necessity and timeliness, but also the control and planning of discharge and management of patient care.

2. Identifying and justifying those areas of individual hospital's activities which appear from financial data to be unnecessarily expensive. It might involve Blue Cross arranging for onsite studies of specific areas.

3. Reducing the per capital project amount requiring approval by the Hospital Survey Committee, Inc. to coincide with that of H.R. 1.

4. Specific means for protecting patients from the exorbitant cost of the building of under-financed and/or excessively expensive facilities.

5. Underutilized facilities which are not voluntarily taken out of service.

6. Positive prevention of potential double payment by Blue Cross and Blue Shield or Blue Cross and subscribers.

7. Staffing levels.

8. Methods to improve Hospital Trustee public accountability.

9. More effective cost containment measures.

Also, we invite your review of the recently published "Study of Health Facilities Construction Costs" by the Comptroller General of the United States in a Report to the Congress of the United States dated December, 1972 which contains many suggestions for cost containment of the health care delivery system.

Exhibit 19

We hope that Council will provide us with input on the various subjects listed above and would also welcome similar suggestions of other specific areas Council wishes to explore.

Sincerely yours,

/s/ BRUCE TAYLOR

BRUCE TAYLOR
President

Exhibit 20

SUMMARY OF PRINCIPLES TO BE UTILIZED IN DRAFTING AN INTERIM 1973 HOSPITAL AGREEMENT

I. The 1971 Hospital Agreement, except where the parties have specifically negotiated changes, shall be utilized as the basic guide in drafting the 1973 Interim Hospital Agreement.

Marked success has been achieved in the Greater Philadelphia area during the past two years in stablizing costs and improving the health care delivery system. This progress suggests the advisability of continuing the 1971 Hospital Agreement, except where changes designed to provide a more viable health care delivery system to serve the needs of the Delaware Valley area community have been negotiated by the parties and are set forth herein. In drafting the new agreement, the 1971 Hospital Agreement will be utilized as a basis, augmented where appropriate to incorporate changes developed by the negotiating parties after consideration of suggestions by the Providers, Blue Cross, the American Hospital Association, Joint Commission on Accreditation of Hospitals, Pennsylvania Insurance Department, and appropriate statutes and regulations.

II. The Utilization Review Program described in Section 11 of the 1971 Hospital Agreement shall be modified to provide for prompt initial review of all hospitalizations, and continuing review and monitoring of hospitalization.

The utilizat on review program to be implemented by all Providers shall include prompt review and establishment of an expected length of stay for all

hospitalizations, whether elective or not, within 60 hours after admission until June 30, 1975, and thereafter within 48 hours after admission (excluding Saturdays, Sundays and holidays).

Blue Cross may retrospectively deny, in whole or in part, any admission or length of stay based upon a determination of medical appropriateness, as hereinafter defined. In the event of an appeal by a physician, or an unresolved difference regarding the medical appropriateness of a hospitalization between Blue Cross and a Provider, the review procedures set forth in Subsection 2.3 of the 1971 Hospital Agreement shall be employed. In this regard, it may be desirable to develop formal review procedures for use by the reviewing county medical societies to ensure continuity and comparability of review.

For purposes of the foregoing, the term "medical appropriateness" shall be interpreted to mean:

1. Hospitalization which is provided at the situs level furnishing necessary Covered Services at the lowest cost consistent with the services rendered.

2. Hospitalization limited in scope and extent to that medically justified by the diagnosis and particular patient's condition.

3. Hospitalization limited in length of stay to that required by the patient's diagnosis as reviewed and approved by the Utilization Review Committee.

4. Hospitalization which is medically required and consistent with the requirements of the: (a) Public Law 89-97, as amended by P.L. 92-603, (b) Pre-Discharge Utilization Review program of the Commonwealth of Pennsylvania for recipients under

the Title XIX Medicaid Program, (c) Pennsylvania Department of Public Welfare as promulgated in the Welfare Assistance Manual at Section 9421.52, and (d) Joint Commission on Accreditation of Hospitals.

III. The present appeal procedure shall be modified to provide for immediate judicial proceedings unless the parties to an unresolved controversy immediately select an appeals board and submit the matter to binding arbitration by it.

The rules and regulations to be followed in cases involving voluntary binding arbitration have not been discussed at length but would generally follow those of the American Arbitration Association applicable to Commercial Arbitration.

IV. A uniform method of current financing will be developed to make payment of Blue Cross reimbursement in the most expeditious basis administratively feasible, encourage prompt billing by hospitals, and provide for advances, if appropriate. In the alternative, a Provider may elect the Medicare Periodic Interim Payment Program.

In order to develop an expedited payment procedure, an improved method will be instituted which essentially will provide for current payment of approved billings, all as more fully described in the attached Exhibit A.

V. The planning of health care facilities as described in Section 24 of the 1971 Hospital Agreement shall be modified to incorporate the changes required by Section 1122 of the Social Security Act (42 U.S.C. Chap. 7).

Exhibit 20

Section 24.1 of the 1971 Hospital Agreement shall be updated as suggested by the 1972 Amendments to the Social Security Act to provide for review of any capital replacement or expansion involving a sum in excess of $100,000.

The failure of H.E.W. to promulgate regulations which specifically delineate the responsibilities of local area wide planning agencies suggests that it may be necessary to revise Section 24. It is the hope of the parties that prior to execution of the 1973 Interim Hospital Agreement some accord can be reached between the Hospital Survey Committee and the present state-designated Regional Comprehensive Health Planning agency as to responsibilities and financing so that conflicts between the two organizations can be avoided.

VI. A program will be continued or provided which will supply patients with information regarding hospital proced[illegible]s and practices.

Guidelines 39, 41, 42, 44, 45, 48 and 54 as presented by the Pennsylvania Insurance Commissioner should be satisfied by a program which insures that patients are advised of the Provider's facilities, services and practices in a timely fashion. Recognizing that the majority of Providers now provide comprehensive patient booklets, an effort shall be made to require all Providers to develop a comprehensive patient booklet for distribution at admission and questionnaires for circulation to patients regarding their treatment. In this regard, a patient Bill of Rights may be developed for adoption by individual Providers after adaption to their particular institution.

Exhibit 20

VII. Blue Cross shall have the right to review the various estimates of expense contained in the budgets submitted for establishment of interim per diem rates, as well as all data and reports supporting the budgeted costs.

Section 18 of the 1971 Hospital Agreement requires that the Provider annually submit its budget to Blue Cross for review and use in developing interim in-patient per diem rates. In this regard, it is recognized that Blue Cross has the right to question budget data and make reviews to substantiate the claimed budget estimates. To permit area hospitals to realize the economies possible through adoption of new management techniques and ideas, Blue Cross may, at the request of a Provider, supply consultants who shall review various aspects of the hospital's operations with the Provider's management and suggest cost-saving procedures.

VIII. The 1973 Interim Hospital Agreement shall be effective as of July 1, 1973 and continue thereafter until March 31, 1974. The continuation provisions contained in Section 27 of the 1971 Hospital Agreement shall apply following termination except that the ninety day period provided in clause (a) shall be extended to ninety-one days for purposes of the 1973 Interim Hospital Agreement.

This Summary of Principles and including by reference thereto, the 1971 Hospital Agreement, shall constitute the basis for a temporary contractual relationship between the Provider and Blue Cross subject to the submission of a formal written contract for execution by the parties following approval of the Pennsylvania Insurance Department. The formal contract shall by this Agreement be completed and readied by representatives of Blue

Exhibit 20

Cross and the DVHC Negotiating Committee for delivery to the Insurance Department not more than 60 days after the date hereof.

Agreed to and accepted this day of 197 .

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

_____
Name of Provider

By _____

_____
Title of Signing Officer

During the period from the date the attached Principles is approved and June 30, 1974, Blue Cross and DVHC, on behalf of the undersigned Provider, shall negotiate in an effort to resolve the following open items:

1. Possible implementation of a form of pre-admission review for all elective cases.

2. The positions of the respective parties with regard to the following areas:

a. Construction of new health care facilities and expansions or modifications of existing facilities must be thoroughly reviewed with specific emphasis and study of each project's financial viability.

b. In order to encourage the elimination of excessive standby facilities and services, studies as to the continuing need for such facilities and

Exhibit 20

services will be undertaken by the appropriate areawide planning agency when experienced occupancy is below certain established minimums.

During the period from the date the attached Summary of Principles is approved and June 30, 1974, the parties hereto agree to actively support, and to solicit others such as labor, Greater Philadelphia Chamber of Commerce, Greater Philadelphia Movement, to support, efforts to develop through all levels of government programs designed to resolve the problems of hospitals resulting from unreimbursed hospital services as a part of their community service.

BLUE CROSS OF GREATER PHILADELPHIA

By _____

By _____

DELAWARE VALLEY HOSPITAL COUNCIL

By _____

Agreed to and accepted this day of 1974.

_____
Name of Provider

By _____

_____
Title of Signing Officer

Exhibit 20

EXHIBIT A

Proposal for Current Reimbursement Policy to Provide Interim Payments to Providers in the Most Expeditious Manner Administratively Feasible

The basic premise upon which this current reimbursement policy is based is for payment to be constructively received by the Provider as promptly as possible following the patient's discharge.

Based also upon a further premise of the reasonable expectation that the Provider will promptly complete and submit subscribers' bills within seven days after discharge, and Blue Cross shall process bills within six days after receipt, plus an allowance of two days for mail deliveries, or a total of fifteen days, Blue Cross proposes to implement the following payment policy program:

1. The amount of payment for current inpatient subscriber discharges will be determined by the projected number of subscriber discharges during an average fifteen day period multiplied by the projected average Blue Cross allowable cost per case, predicated on budgeted data approved by Blue Cross.

2. The amount of payment for current outpatient subscriber services shall be calculated on the Provider's average calendar day experience of payments by Blue Cross for such services in the most recent available fiscal year, multiplied by fifteen days.

3. The amount of payment for current maternity, nursery and 65-Special indemnity services shall be calculated on the Provider's average calendar day experience of payments by Blue Cross for such services in the most recent available fiscal year, multiplied by fifteen days.

Exhibit 20

4. In the event that the Provider is unable to complete its billing procedure in the time requirement that will provide payment within the fifteen day cycle, the Provider may, at any time request, subject to the approval of the Blue Cross, an additional supplementary payment in an amount equal to the amount provided in Items 1, 2 and 3 above.

5. The supplementary amount will be subject to a payment by the Provider to Blue Cross for interest at a rate of one and one quarter percent above the prime rate of interest charged by The First Pennsylvania Company. Interest to be calculated monthly by Blue Cross with the amount of interest payable deducted from the succeeding remittances. Such interest shall be considered in the same category as any other interest paid for working capital borrowing as an allowable cost.

6. The supplementary payments shall be repaid by the Provider to Blue Cross on mutually acceptable terms, but in no event shall any amount of supplementary payment remain outstanding beyond the date of termination of this agreement.

7. The basis upon which the original calculation was based will be reviewed in conjunction with the receipt from the Provider of current data, e.g. Financial, Statistical, Budget Revisions, etc. for possible revision to assure adequacy of the current payments provided.

8. In the event that any of the advances currently outstanding exceed the amounts available under this agreement, Blue Cross will deduct the over-payment from the subsequent remittances in a pro-rata amount to assure repayment within ninety days, after receipt of notice by Blue Cross.

Exhibit 20

9. To facilitate cash flow to Providers, Blue Cross shall adopt procedures for the processing and paying of approved subscribers' bills received on a *daily* working basis, with detailed remittance listings.

10. Blue Cross agrees to implement the above current reimbursement policy as soon as administratively feasible following member hospitals' ratification of the agreements in principal arrived at during negotiations with DVHC Committee for a new Blue Cross Hospital Agreement.

11. Blue Cross shall submit, upon request, any and all data to Providers necessary to complete the calculations required for the determination of the allowable amounts hereunder.

ADDENDUM No. 1

Any Provider desiring to participate in the following optional program may so elect by executing this Addendum No. 1 to this Summary of Principles.

During the period of the 1973 Interim Hospital Agreement, Blue Cross will establish and finance Experimental Programs in order to give Providers a new impetus in their efforts to develop an innovative and efficient health care delivery system which meets the medical needs of the communities they serve. The detailed methodology to be utilized in designating and implementing these Programs is set forth in the attached Exhibit.

Exhibit 20

Agreed to and accepted this day of 197 .

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

_____
Name of Provider

By _____

_____
Title of Signing Officer

EXPERIMENTAL PROGRAMS

In an effort to encourage new studies and the development and implementation of improved procedures and methods designed to ensure quality health care in the most cost effective manner, Blue Cross and the Provider parties to the Summary of Principles Agreement (the "Summary Agreement") have jointly developed the following program:

1. Blue Cross shall establish a special segregated fund equal to $15.00 per Blue Cross inpatient case (excluding 65 special cases) paid to all Providers electing to participate in this program. The sum to be allocated to the fund monthly shall be based on the total Blue Cross payments to eligible Providers during that month. The amounts shall be computed from the effective date of the 1973 Interim Hospital Agreement, with the initial payments to be made within 30 days after the date an eligible Provider executes the Summary Agreement.

2. All Providers that are parties to the Summary Agreement shall be eligible for participation in the program. However, within any single fiscal year, each Pro-

vider shall only be eligible to receive grants equal to or less than 3% of its annual Blue Cross payments.

3. The program shall be administered by a Review Committee composed of seven members of which two shall be appointed by Blue Cross. All eligible Providers, in an election conducted by the Delaware Valley Hospital Council, shall elect two members of the Review Committee, with the other three members consisting of the Executive Director of the Philadelphia Health Management Corporation, and one representative each of the Greater Philadelphia Chamber of Commerce and Greater Philadelphia Movement. Each representative shall have the right to designate an alternate and a majority of the representatives or their alternates shall constitute a quorum for doing business.

The Review Committee shall meet at least quarterly to review applications and make commitments under the program. In conducting this function the Committee shall consider only projects or studies (i) whose results can be evaluated, measured and quantified; and (ii) which have received the endorsement of the Provider in interest and Blue Cross.

Any amounts remaining uncommitted at the end of each calendar quarter, commencing June 30, 1974, after consideration by the Review Committee of all proposals, shall be credited to the subsequent quarterly allocations by Blue Cross with any amounts not expended upon the expiration of the 1973 Interim Hospital Agreement to be returned to the general funds of Blue Cross.

4. Eligible Providers would submit to the Review Committee applications for grants to study specific problems or areas and include the following information.

a. Complete and specific documentation as to the needs of the hospital and local community.

b. A specific proposal for use of grant funds with a complete proposed budget.

c. A schedule for implementation of the proposal, including a schedule over which the funds are to be provided and the total amounts minimally required over the life of the program.

d. An explanation of how the proposal would deal with the needs of the community and hospital.

e. A system for regular reports to the Committee which would document expenditures and benefits. Such reports would be made on no less than quarterly basis and include actual performance evaluations.

5. In selecting appropriate proposals for funding, the following are to be given priority:

a. Projects involving hospitals experiencing the greatest net losses in providing services to satisfy the needs of the local community.

b. Projects which will result in the greatest cost saving to both the individual hospital and the local community.

c. Projects involving joint programs among a number of hospitals.

d. Projects involving improvement in the quality of health care.

6. In evaluating the desirability of a given proposal, the Review Committee should consider the following objectives.

a. The basic objective of the experimental plan or proposal as to achieving affectivity and greatest economies without adversely affecting the quality of services provided.

(i) The experimental plan must be a plan whose precedents could not be tested without some change in the application of the present group improvement provisions.

(ii) Although minor capital expenditures may be incorporated as part of a broader-scale plan, major capital expenditures will not be considered eligible for inclusion.

7. All proposed plans must be given reasonable promise and expectation of achieving the basic objective within a reasonable period of time.

8. Participation in a plan must be voluntary for both Blue Cross and the Provider.

9. Application for establishment of an experimental plan can, in addition to hospitals, also be filed by or for physicians, physician groups, clinics, and other individuals or organizations interested in improving the effectiveness of the delivery of health care services to the community.

10. The quality of care provided to beneficiaries under the experimental plan must be maintained or improved.

11. The size, scope and comprehensiveness of a proposal shall be considered in judging the significance of the proposal.

12. The results of the proposal must be capable of the evaluation and the magnitude of specifics quantifiable. The proposal should include a well-developed statistical model which should clearly explain: (i) the objective to be achieved; (ii) the nature of the evaluation proposed; (iii) the type and detail of data to be collected, including the

sample methods to be employed; (iv) the manner in which quality of care will be measured and the controls to be employed; (v) the overall validity of the experiment.

13. The Review Committee may engage consultants, or other assistants, as it feels necessary to aid in the evaluation of such suggested proposals. The cost of such consultants, as well as any consultants used in studying a given proposal submitted pursuant to this program, shall be paid out of the funds established by Blue Cross under this program.

14. The funds provided under this program may be disbursed by Blue Cross to the consultant, agency performing the project or study approved by the Review Committee. Any funds authorized by the Review Committee to be used as developmental funds shall be disbursed by Blue Cross to the Provider as a developmental grant over a period of time as provided in the consultant's recommendation.

15. Any general or special management study or project which is funded pursuant to Section 14 of the Hospital Agreement shall not be duplicated or funded under the program.

16. The results and distribution of all projects, studies and evaluations undertaken pursuant to this program, may be published for the benefit of all health care Providers, without advising the specific hospital involved.

17. Any sums provided under this program are to be used only as budgeted in the submitted application as approved by the Review Committee. Monies provided under this program are not available for off-setting operating losses.

18. All actions taken by the Review Committee require the affirmative vote of at least four members, pro-

vided, however, if the reviewing consultant or the Review Committee determines that granted funds provided hereby have not been used as approved, such grant may be terminated immediately by a majority vote of the committee. In such a case, the affected Provider would be required to repay any such grant within three months of the date of revocation.

19. Periodic reports of funds authorized shall be rendered to all participating Providers by Blue Cross at least quarterly.

ADDENDUM No. 2

Any Provider desiring to participate in the following optional program may so elect by executing this Addendum No. 2 to this Summary of Principles.

In addition to the basic utilization review program outlined in Principle II, the new agreement shall permit each Provider to elect a "comprehensive utilization review program" similar to the Quality Assurance Program QAP sponsored by the American Hospital Association, which is acceptable to the Provider and Blue Cross, for individual implementation. In such event Blue Cross, in recognition of the significant start-up costs of such a program, would provide developmental financing equal to $10.00 per Blue Cross inpatient case (excluding 65 special cases) in addition to its reimbursement of this allowable cost. Payment of the developmental financing would, of course, be conditioned upon continued adherence to such an acceptable program. Further, a Provider which has implemented an acceptable comprehensive utilization review program shall not retrospectively

be denied reimbursement by Blue Cross for hospitalizations reviewed pursuant to such a program. It is agreed that the question as to whether the Provider's comprehensive utilization review program is being satisfactorily implemented and continued shall be subject to a special review procedure.

A temporary waiver of the requirements of preadmission certification and the review of emergency admissions within twenty-four hours after admission will be granted, retroactive to July 1, 1973, for those hosptials which have implemented QAP, or a similar program except for the foregoing two requirements as of the date of execution of this Addendum No. 2. This temporary waiver is conditioned upon the implementation within 30 days after the execution of this Addendum No. 2 of the aforesaid two requirements by the Provider requesting such waiver.

Agreed to and accepted this day of 197 .

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

_____
Name of Provider

By _____

_____
Title of Signing Officer

Exhibit 23

IN THE COURT OF COMMON PLEAS OF
DELAWARE COUNTY, PENNSYLVANIA

No. 9799 of 1974

CROZER-CHESTER, et al

vs.

BLUE CROSS OF GREATER PHILADELPHIA

Media, Pa., September 25, 1974

AGREEMENT

Before: HON. HOWARD F. REED, JR., J.

APPEARANCES: FRANK H. ABBOTT, ESQ.,
I. HARRY CHECCHIO, ESQ.,
CHARLES C. HILEMAN III, ESQ.,
BRENDA C. KINNEY, ESQ.,
JOSEPH T. LABRUM, JR., ESQ.,
For the Plaintiffs;

DENIS V. BRENAN, ESQ.,
MURRAY S. ECKELL, ESQ.,
DAVID S. MARKSON, ESQ.,
MARC J. SONNENFELD, ESQ.,
For the Defendant.

Exhibit 23

AGREEMENT

1. During the runout period Blue Cross will pay the hospitals named in Exhibit 1 attached the interim rates set forth times the number of Blue Cross days less co-pay immediately retroactive to July 1, 1974, provided however that the rates of the following hospitals, Germantown, Holy Redeemer, Jeanes, Northeastern, Paoli, Suburban, Nazareth, Frankford, St. Agnes, West Park, Sacred Heart-Norristown, Montgomery, Chestnut Hill, and Magee, shall be adjusted to reflect any increased costs applicable to food, fuel or utilities (excluding telephone but not the increase resulting directly from any discontinuance of the charitable allowance), which will be allowed as flow-through items.

2. Any difference between the approved budgeted rates and the requested budgeted rates for fiscal 1974-75 will be resolved immediately by representatives of Blue Cross and each hospital. If any differences cannot be resolved within two weeks, it shall be referred to Frank H. Abbott, Esquire, and Allen W. Stewart, Esquire. Any differences between them shall at the request of either be referred to Judge Howard F. Reed, Jr., who shall have full authority to set the budget rate.

3. In accordance with the procedures heretofore applied in adjusting interim rates for hospitals as of March 31, 1974, Blue Cross shall make appropriate increases in the current interim rates if indicated, based upon the nine-month operating statement and statistical report as of March 31, 1974, retroactive to July 1, 1973, for those hospitals which have not submitted their third quarter report or whose third quarter reports were not considered due to late filing. These hospitals agree to submit accurate reports, and any dispute with respect to such reports shall be resolved in accordance with Paragraph 2 above.

Exhibit 23

4. In accordance with the provisions of the July 1, 1971 Agreement as later modified, but without regard to the July 1, 1972 Amendment, Blue Cross will pay full reasonable costs at the end of and for the runout period.

5. The runout period herein referred to shall be August 16, 1974, to and including August 15, 1975.

6. This Court will retain jurisdiction.

7. The parties agree that negotiations will continue in good faith toward the consummation of a new hospital agreement.

8. This agreement is a final settlement of this lawsuit only and relates only to the runout period and is without prejudice to any other rights of the parties, and shall not be used by plaintiff hospitals to attempt to adversely affect the negotiations of Blue Cross with any other hospital.

EXHIBIT I

Hospital	*Rate*
Crozer-Chester	$139.23
Fitzgerald-Mercy	$109.44* **
Misericordia	$109.44* **
Riddle Memorial	$107.29
Sacred Heart General	$109.56
Taylor	$102.67
Abington	$103.42
Bryn Mawr	$130.22
Episcopal	$140.75*
Germantown	$105.69
Holy Redeemer	$100.69

* These hospitals are entitled to consideration under Paragraph 3 of the Agreement.

** These hospitals are granted the privilege of submitting a new budget.

Exhibit 23

Hospital	*Rate*
Jeanes	$ 88.40*
Lankenau	$137.84*
Methodist	$121.08
Northeastern	$111.41
Paoli	$113.16
St. Joseph's	$ 95.95*
Memorial Roxborough	$104.08
Suburban General	$104.02*
JFK Philadelphia	$ 91.63*
Nazareth	$ 90.86
Frankford	$119.87
St. Agnes	$128.06*
Metropolitan	$132.17
West Park	$111.70*
Sacred Heart-Norristown	$ 86.06*
Montgomery	$ 95.89*
Chestnut Hill	$122.70
Presbyterian	$137.96*
Magee	$117.83

* These hospitals are entitled to consideration under Paragraph 3 of the Agreement.

** These hospitals are granted the privilege of submitting a new budget.

It is further understood as an addendum to this Exhibit 1, that any hospitals which have submitted cost reports as of this time are not entitled to submit another such report.

Exhibit 24

STATEMENT OF THE MEDICAL SCHOOL HOSPITALS OF PHILADELPHIA

TO THE DELAWARE VALLEY HOSPITAL COUNCIL

August 14, 1974

Over the past months, The Delaware Valley Hospital Council and Blue Cross of Greater Philadelphia have been engaged in negotiations in an attempt to develop a new contract between Blue Cross and the hospitals of the Greater Delaware Valley. Through the course of these negotiations certain issues have arisen which have created an impasse to an agreement between The Delaware Valley Hospital Council and Blue Cross, and have given the appearance of the existence of animosity between the hospitals and Blue Cross.

The Medical School Hospitals of Philadelphia—mindful of their responsibilities to their patients, their medical staffs, and the community—believe that the time has come to set forth clearly their position regarding these issues so that the Delaware Valley Hospital Council, other hospitals in the Delaware Valley, the public, and Blue Cross may be aware of a philosophy which differs in some respects from the public posture of the Delaware Valley Hospital Council. We undertake to make this statement with deep consideration of the desirability of maintaining a common "hospital" position in negotiating with Blue Cross. However, the intensity of the feeling about certain basic philosophical differences between Blue Cross and the hospitals is so great that we believe it necessary to formally express our beliefs and our position with respect to the negotiation of a new contract with Blue Cross.

The tenor of the negotiations and the public pronouncements of many parties participating in the negotiations have been characterized by a hostility and animosity that we believe to be inappropriate for organizations dedicated to effective health care delivery. The Medical School Hospitals believe that the relationship between the hospitals and Blue Cross should be business-like and professional but should also be characterized by a cooperative attitude of mutual support to benefit the welfare of our patients. We do not view Blue Cross as an adversary but as a participant in the health care delivery system.

Exhibit 24

A major unresolved issue in the negotiation for a new contract has been the proper role of Blue Cross in assisting the hospitals in their responsibility for cost containment. This problem has focussed on the imposition by Blue Cross of ceilings on increases in cost, which are regarded by many as arbitrary. The Medical School Hospitals believe that it is appropriate for Blue Cross to have an interest in the levels of cost incurred by hospitals in the provision of services to Blue Cross subscribers. Such provisions, if included in a Blue Cross contract, should be reasonable in the light of existing economic conditions, equitable to all providers, should provide for specific and identified circumstances under which the limitations would be waived or adjusted, and should provide a mechanism under which disputes would be equitably and expeditiously resolved. We believe that an attempt should be made to pursue negotiations with Blue Cross to embody these principles in a new contract and in the settlements related to the existing contract.

On a number of occasions various contract offers have been rejected by both Blue Cross and The Delaware Valley Hospital Council. In many of the cases representatives of the Medical School Hospitals have joined in those votes of rejection of Blue Cross offers in the belief that the offers were not adequate, equitable, appropriately

Exhibit 24

detailed, or otherwise sufficient to merit a vote of approval. However, the Medical School Hospitals believe that it is in the best interest of our patients and our institutions to continue our contractual relationship with Blue Cross. Therefore, we urge the Delaware Valley Hospital Council to continue its negotiations with Blue Cross within the spirit of the principles outlined in this statement, and to take such steps as necessary to insure coverage for Blue Cross patients within our hospitals. If the Delaware Valley Hospital Council determines that such negotiation and continued contractual relationship can no longer be pursued under its auspices, the Medical School Hospitals will withdraw their grant of authority to the Delaware Valley Hospital Council to negotiate on their behalf and will seek to enter into negotiations directly with Blue Cross. In this event we will welcome other hospitals who share a community of interest with us in our negotiations with Blue Cross.

We understand the seriousness of the actions that we propose, but we also are mindful of the seriousness of the conditions and circumstances which give rise to our plan of action and assure all interested persons that we undertake this course of action only after careful and serious deliberation and in consideration of our community obligations.

F.H. Barth Pavilion of the Philadelphia College of Osteopathic Medicine

Hospital of the University of Pennsylvania

Temple University Hospital

The Graduate Hospital of the University of Pennsylvania

The Hahnemann Medical College and Hospital of Philadelphia

The Hospital of the Medical College of Pennsylvania

Thomas Jefferson University Hospital

Exhibit 25

MEMORANDUM OF AGREEMENT

Representatives of Blue Cross of Greater Philadelphia (the "Plan") and an Ad Hoc Hospital Committee representing numerous area hospitals have jointly developed the basis for a new Hospital Agreement. While drafts of the specific contract language have not yet been finalized, the parties have reached an understanding in principle and agree that the Hospital Agreement, dated July 1, 1971, as revised by the 1973 Summary of Principles and the Addenda thereto, shall constitute the basis for a new contract after appropriate modification for the following jointly negotiated matters:

1. The Agreement shall be effective as of July 1, 1974 and continue thereafter on a year-to-year basis for a five year term, subject to annual review by the Joint Provider-Plan Committee. The Agreement shall include appropriate provision for amendments and reopening, if indicated by major changes significantly affecting the health care delivery system or in the event of new federal, state or municipal actions, such as National Health Insurance, which would significantly affect the existing arrangements between the parties.

2. A Joint Provider-Plan Committee designed to promote greater understanding and enhance the working relationships between the parties will be established. The specific composition of this Committee as well as its responsibilities, duties and procedures are detailed in the attached Annex A.

3. The Providers will establish a Standing Peer Review Board composed of 12 Provider and 6 public members which shall informally review individual Provider-Plan disagreements, if any. The detailed procedures,

method of appointment and scope of inquiry assigned this Board are detailed in the attached Annex B.

4. The maximum permissible percentage increase in the rate of reimbursement to be paid each Provider shall be established annually, both with respect to interim rates and final payments. This permissible increase shall be 125% of the median percentage increase after allowance for certain adjustments and flow through items. The maximum permissible increase in interim rates shall be computed on a per diem basis, but its application to final payments may be on an inpatient per diem or per case basis, or a total overall cost basis, as retrospectively elected by the Provider. The specific methodology which will be employed in making the foregoing calculation is set forth in the attached Annex C.

5. The Plan shall not reimburse a Provider for educational costs applicable to interns and residents in excess of that annual percentage increase determined as in paragraph 4; provided, however, that this limitation shall apply only if Provider's cost for this line item exceeds a base cost of $5.00 per inpatient day for fiscal 1974-1975 and $5.00 plus the foregoing percentage increase in the prior fiscal year's base for each fiscal year thereafter. At the request of Provider this limitation will be reviewed, and may be modified by the Plan to reflect extraordinary fiscal year fluctuations attributable to the availability of interns and residents or intensified or expanded medical services, when such are adequately substantiated by Provider.

6. A hospital index computed as described in Exhibit F to Annex C will be used to measure price changes during each fiscal year under this Agreement. If the index experiences a percentage change which exceeds the median rate of increase developed as in paragraph 4 above, the

maximum permissible percentage increase in the rate of reimbursement will be recomputed by multiplying the percentage change in the index during the fiscal period by 125% and adding one-half of one percent thereto to reflect intensity factors which may not have been reflected in the approved budgets. In the event the index declines in a subsequent quarter during the fiscal year the maximum permissible percentage increase will be adjusted accordingly so that at the end of fiscal year the maximum permissible percentage increase will be determined using the greater of the median rate of increase or the actual annual change in the index during the fiscal year.

7. As an incentive for all hospitals to exert continuing cost containment measures, the parties have agreed that if a particular Provider exceeds the maximum permissible percentage increase in the rate of reimbursement in any fiscal year but within three years thereafter experiences a percentile increase in inpatient costs over the prior fiscal year, computed as in paragraph 4, which is less than the median percentile increase, the Plan will reimburse the Provider those previously disallowed costs to the extent that the difference in the subsequent fiscal year's percentage increases, as compared with the maximum percentage increase permissible in that year, times that year's inpatient Plan cost, is less than or equal to such unreimbursed amount, as more fully described in Annex C.

8. The parties will review and may amend, when and as appropriate, those sections of the 1971 Hospital Agreement, as modified by the 1973 Summary of Principles, which provide for review by the Hospital Survey Committee in order to recognize any acceptable compact or agreement between the Hospital Survey Committee and the Regional Comprehensive Health Planning Agency, or their successors.

Exhibit 25

9. The parties understand that the Plan may offer the proposed Agreement to other hospitals in the area, but that the Plan warrants and represents that in the event another form of contract is offered generally to short-term acute voluntary non-profit Pennsylvania hospitals, its provisions will be designed to maintain reasonable parity with this Agreement.

10. The Experimental Program option which is included as an addendum to the 1973 Summary of Principles shall be part of the Agreement with the allowance per Plan inpatient case established at $10.00. This accrual will be initiated by the Plan for all Providers executing this Agreement as of the first day of the calendar month next following the date this Agreement is approved by the Pennsylvania Insurance Department. The Joint Provider-Plan Committee shall serve as the Review Committee for purposes of approving eligible programs.

11. Any hospital having a short-procedure unit which has been approved by the Plan may elect to be reimbursed for services rendered by such unit under any of the three options permitted by subsection 2.4.2 of Exhibit A to the 1971 Hospital Agreement, which election shall be separate and apart from its election as to reimbursement for outpatient services. Attached as Annex D is a list of those guidelines to be utilized in establishing and qualifying a short procedure unit.

12. The unrestricted grant to be paid all hospitals qualifying for such amounts under the Optional Utilization Review Program that was added by the 1973 Summary of Principles shall be continued and raised to $12.50 per inpatient Plan case commencing with the effective date of this Agreement (excluding those cases paid under the Medicare supplemental coverage). Furthermore, as of the first day of the calendar month next following the date this Agreement is approved by the Pennsylvania Insurance Department, the Plan will commence making additional grants to qualified Providers to encourage and

Exhibit 25

assist in the development of an effective outpatient utilization review program. The amount of such grants shall be calculated on the basis that two short procedure unit cases equals one inpatient case and five emergency room cases equals one inpatient case. Within six months after initiation of these outpatient grants, each qualifying Provider shall submit to the Plan a report detailing the program of outpatient utilization review (which program shall include provision for peer review) that the Provider has implemented. If a Provider fails to implement a program of outpatient utilization review with such six month period it shall return to the Plan any grant payments previously received.

The Joint Provider-Plan Committee shall, within nine months after the date of the initiation of outpatient grants, develop specific criteria as to outpatient utilization review. Each Provider shall thereafter have a period of three months following the publication of these criteria to modify, if necessary, its own program of outpatient utilization review so as to conform with these guidelines and as evidence thereof shall submit appropriate reports to the Joint Committee for review and approval. At the end of this three month period only those Providers which have an outpatient utilization review program that has been approved by the Joint Committee shall qualify for outpatient grants.

13. This Agreement will be implemented by the various Providers and the Plan as soon as possible after its approval by the Pennsylvania Insurance Department.

14. Reimbursement to Providers for the fiscal year ended June 30, 1974 will be settled utilizing the same criteria and methodology as set forth in this Agreement although the maximum permissible percentage increase in the rate of reimbursement will be calculated using the

fiscal year 1974 cost data submitted with the fiscal 1975 budget rather than fiscal year 1974 budgeted data as the basis for determining the median increase.

15. The terms of the existing relationship between the Plan and Providers executing this accord will be continued until the Agreement is implemented as provided in paragraph 13.

16. Subsection 21.2 of the 1971 Agreement will be modified to include a requirement that the Appeals Board determine if the Plan as well as the Provider has acted unreasonably in forcing a matter to arbitration.

17. Appropriate changes will be made in the language of the 1971 Hospital Agreement, the 1973 Summary of Principles, and this Agreement as agreed to by counsel for the respective parties, in order to provide greater clarification.

The parties hereto, intending to be legally bound have caused these presents to be executed by the proper officers as of the date set forth below.

Date of Execution:

BLUE CROSS OF GREATER PHILADELPHIA

_____

By: _____

_____

Name of Provider

By: _____

_____

Title of Signing Officer

Annex A

JOINT PROVIDER—PLAN COMMITTEE

In order to realize the objectives set forth in the preamble of the Agreement, promote greater understanding and enhance the working relationships between Providers and the Plan, a Joint Provider—Plan Committee (Joint Committee) shall be established to provide for joint review and evaluation of evolving concepts of mutual interest which may arise during the term of the Agreement.

1. *Composition of Joint Committee*

The Joint Committee shall initially consist of six Provider members constituting the "Provider Committee", and six Plan members constituting the "Plan Committee". The initial organizational meeting of the Joint Committee shall be held within 60 days after this Agreement is implemented.

The Provider members shall be nominated and elected by majority vote of all Providers contracting with the Plan under agreements which include provision for a Joint Provider—Plan Committee, with each such Provider having one vote. Provider members shall represent a cross-section of such Providers and nominations shall reflect the requirement that the Provider Committee at all times include at least one member from a medical school hospital, an other major teaching hospital, a non-teaching hospital, a specialty hospital and a suburban hospital. Of the six Provider members, two shall be initially elected for a period of one year, two for a period of two years, and two for a period of three years; thereafter, members shall be elected for a period of three years. Mr. Charles Paxson, with the aid and assistance of

the other members of the Ad Hoc Hospital Committee, shall take appropriate action to ensure that the initial election of the Provider Committee is completed within sixty days after this Agreement is approved by the Pennsylvania Insurance Department.

The Plan Committee membership shall be appointed by the Plan with two members being initially appointed for a period of one year, two for a period of two years, and two for a period of three years; thereafter, members shall be appointed for a period of three years.

The Provider and Plan Committees shall each elect a chairman from its membership at the time of Joint Committee's annual meeting. In odd-numbered calendar years the Chairman of the Provider Committee shall be the Chairman of the Joint Committee and in even-numbered calendar years the Chairman of the Plan Committee shall be Chairman of the Joint Committee.

The Chairman of the Provider Committee shall, at least semi-annually, submit a report to the Plan's Executive Committee with regard to matters considered by the Joint Committee, and if requested by the Plan's Executive Committee, attend a meeting of the Plan's Board of Directors to discuss the aforesaid reports.

The Joint Committee may be expanded beyond the originally designated number by the mutual agreement of the Provider and Plan members.

2. *Meetings of the Joint Committee*

The Joint Committee shall hold its annual review meeting in December of each year beginning with 1975 for the purpose of evaluating this Agreement and its impact on the parties. The Joint Committee shall hold regular quarterly meetings, in order to carry out its functions as hereinafter delineated. Additionally, special meetings shall be called by the Chairman within 15 days

upon receipt of a written request of any four members to the Chairman. At all such meetings a quorum shall consist of not less than three Provider and three Plan members.

3. *Procedures of the Joint Committee*

3.1 The Joint Committee shall at its first meeting, establish a general organizational structure and operating procedures to be used in carrying out its various functions. Nothing therein, however, shall preclude the Joint Committee from inviting individuals and organizations having special expertise to participate and present data regarding the various areas under discussion; or from forming sub-committees to study particular subjects as the Joint Committee sees fit; or from other approaches which the Joint Committee may deem appropriate to provide necessary assistance to the Joint Committee. In this connection, the Provider and the Plan agree to cooperate fully with the Joint Committee and provide it with such data consistent with disclosure policies, as may from time to time be requested.

3.2 The Joint Committee shall have a written agenda for all meetings and such will be sent to each member at least five days prior to all scheduled meetings.

3.3 Recommendations of the Joint Committee shall be made only by joint agreement reflecting concurrence of a majority of Provider members and a majority of the Plan members present and shall be transmitted to the Providers and to the Plan for appropriate consideration by their governing bodies.

4. *Additional Duties and Responsibilities of the Joint Committee*

4.1 The Joint Committee shall be responsible for verifying the calculations made by the Plan as to the

median and maximum permissible percentage increases in costs, and the Provider by executing this Agreement agrees that such information, which shall be treated as confidential and privileged by the Joint Committee, may be released by the Plan for this limited purpose.

4.2 Within nine month after the date the Plan commences payment of grants for outpatient utilization review the Joint Committee shall develop written criteria for use by Providers in creating an effective out-patient utilization review program. Thereafter, the Joint Committee shall review and approve, as appropriate, individual Provider plans, which when implemented, would qualify for grant payments by the Plan.

4.3 All applications by Providers seeking funding for Experimental Programs, must be submitted to the Joint Committee for review and approval based on the criteria set forth in the 1973 Summary of Principles.

4.4 The Joint Committee shall review the guidelines for Short Procedure Units which are attached as Annex D and may from time to time recommend changes to those guidelines.

Annex B

STANDING PEER REVIEW BOARD

1. *Function*

In the event of any disagreement between an individual Provider and the Plan that cannot be resolved by informal conference between them, the disagreement shall first be referred in writing to a Standing Peer Review Board for review and recommendation.

2. *Composition of the Peer Review Board*

The Board shall consist of 12 members elected by a majority vote of all Providers contracting with the Plan under agreements including this provision, and six public members of which three will be designated by the Greater Philadelphia Chamber of Commerce, and three by the Greater Philadelphia Movement from among their respective memberships. Provider members shall represent a cross-section of all hospitals contracting under agreements providing for a Peer Review Board and nominations shall reflect the requirement that the Board at all times include at least one member from a medical school hospital, an other major teaching hospital, a non-teaching hospital, a specialty hospital and a suburban hospital. No person shall be designated a public member who is a member of the governing body or an employee of any health care provider in the Greater Delaware Valley area or the Plan. Initially, one third of the Board shall be elected or appointed for a period of one year, a third for two years and a third for three years. Thereafter, individuals elected or appointed to the Boa. will serve for three-year terms, and may serve no more than two consecutive terms. Mr. Charles Paxson, with the aid and assistance of the Ad Hoc Hospital Committee, shall take appropriate action to ensure the Board is elected and holds its initial organizational meeting within sixty days after this Agreement is implemented.

The Board shall elect a Chairman and a Vice Chairman at its initial organizational meeting who shall serve in the absence of Chairman.

3. *Designation of Peer Review Panels*

Whenever the Board receives a written request to recommend a solution to a disagreement, the Chairman,

within ten days after receipt thereof having determined that informal conferences have failed to resolve the differences, shall designate a Peer Review Panel of five Board members of which three shall be Provider representatives, one of whom shall be designated as Chairman by the Chairman of the Panel, and the remaining two shall be public members.

4. *Peer Review Panel Procedures*

The Peer Review Panel will conduct informal hearings with regard to those matters referred to it by the Chairman of the Board within 15 days from the date of the Panel's appointment at which hearings both parties will appear, present testimony and respond to questions. A recommendation signed by a majority of the Panel shall be made within 15 days of the hearing and submitted in writing to the parties and the members of the Board.

5. *Board Review*

Upon the written request of six Board members, filed within ten days after receipt of a Panel's written recommendation, the Board will meet to review the Panel's action. Any such meeting shall be held within 30 days after receipt of the Panel's recommendation. The results of any Board review concurring with or modifying the Panel's recommendation shall be submitted to both parties within 15 days after the meeting. The parties to this Agreement understand and agree that the recommendations entered by either a Peer Review Panel or the Peer Review Board are only advisory and shall not bind the parties unless they otherwise agree.

6. *Restriction on Subsequent Action*

The Plan and Provider agree that no action at law or in equity or arbitration in connection with the application, operation or interpretation of this Agreement shall be initiated by either party until it has first exhaused the review procedure hereinabove described and in the event any such action is thereafter commenced, the parties agree and stipulate that the recommendations of the Panel or Board and the record or transcript made before the Panel or Board shall not be offered into evidence; and further, it is agreed and stipulated that neither the Chairman nor any individual member of any Panel or of the Board, or the staff thereof, shall be called to testify before such court or arbitration board as to any matter with regard to any dispute presented to any Panel or to the Board.

7. *Staffing*

The Plan shall provide permanent staff for the Board and its Panels at such time and in such number as may reasonably be requested by the Chairman of the Board.

8. *Confidentiality*

All matters presented to the Board or any Panel shall be treated as confidential and privileged.

9. *Annual Meeting*

The Board shall hold an annual meeting, at which the Chairman will present a report of the activities of the Board and its Panels, and at which time the Board shall consider recommendations for changes in procedure. Elections will also take place at this meeting.

Exhibit 25

Annex C

18.4 *Calculation of Reimbursement.*

The reimbursement to be paid the Provider by the Plan under this Agreement as either an interim payment or pursuant to the settlement procedures detailed in Exhibit A hereto shall be subject to the following:

18.4.1. Subject to the requirements of this Section 18 and subsections 1.4 and 2.4.6 of Exhibit A, Part I, the Provider's permissible rate of increase in costs for any fiscal year shall not exceed the total allowable costs approved by the Plan for the previous fiscal year, plus such increase as may be permitted by subsection 18.4.2. hereof.

18.4.2. Upon receipt of budgets from those non-profit hospitals contracting with the Plan under accords requiring that budgets similar to those described in Exhibit B be submitted and reviewed, the Plan shall determine each Provider's percentile change in its budgeted inpatient per diem costs as compared to the prior fiscal year's allowable inpatient per diem costs, after adjusting both in accordance with subsection 18.4.3. After this percentage change for each such Provider has been calculated, the Plan shall compute the median percentage change for the group as a whole and submit this data to the Joint Provider-Plan Committee for its confidential review and verification, which limited release of information the Provider hereby authorizes. The rate so calculated and verified shall then be multiplied by 125% to establish the maximum permissible percentage increase in inpatient per diem costs for the budgeted fiscal year over the prior fiscal year, subject to those adjustments required by subsection 18.4.3. Similarly, the percentage increase for the budgeted fiscal year applicable to each Provider shall be calculated on both an inpatient per case and total cost

Exhibit 25

basis to determine a median rate of change for the group on each such basis. These rates will then be multiplied by 125% to compute the maximum permissible rate of increase on both an inpatient per case and total cost basis.

18.4.2.1. The initial maximum permissible percentage increase in inpatient per diem rates as described in 18.4.2 shall be calculated by the Plan based upon those budgets received and processed prior to the beginning of each budgeted fiscal year. This initial percentile change shall then be used in fixing the initial inpatient interim per diem rates. Thereafter, the Plan shall again calculate this initial percentile change, prior to each October 31, based upon budgets received and approved on or before September 30, to determine an adjusted percentage change. Finally, on or before January 15 in each fiscal year, the Plan shall recompute the adjusted percentage change based on the prior fiscal year's cost reports that were conditionally approved by the Plan at desk audits completed prior to December 31.

18.4.2.2 On or about the first day of each July, August and September, the Plan will notify the Peer Review Committee of those Providers which have not submitted budgets. No change in a Provider's interim per diem rate shall be made by the Plan for a new fiscal year until such time as the Provider's budget has been submitted to and approved by the Plan.

18.4.2.3. As soon as each Provider's final cost reports for the budgeted fiscal year are conditionally approved by the Plan at the desk audit, the percentage increase in the Provider's allowable costs for that fiscal year shall be compared with the prior year's allowable costs, both adjusted as described in subsection 18.4.3, to determine the percentage increase in inpatient costs on a per diem or per case basis, or an overall total cost basis. The Plan

shall then submit these figures to the Provider for review. In the event one or more of these percentile changes exceed the maximum permissible percentage increase established by subsection 18.4.2, after any adjustment required by subsection 18.4.4, the Provider shall submit to the Plan its initial written election as to which basis (per case, per diem or total cost) it desires to use for purposes of the limitation described herein. Thereafter, at such time as final audited data for the fiscal year is available, the percentage increase on each basis shall again be computed and submitted to the Provider which, if appropriate, will finalize its election as to the comparative basis it desires be used for purposes of the limitation on reimbursement. Once having made a final election the Provider may not change basis without waiving its right to recover amount previously disallowed pursuant to subsection 18.4.5.

18.4.2.4. The rate permitted the Provider shall be adjusted for unanticipated costs (amounting in the aggregate to more than ten cents ($.10) in the inpatient interim per diem rate), including changes in payments by the Provider made pursuant to Sections 14 and 24 as well as the cost associated with implementing the recommendations of studies made pursuant to Section 14 hereof when such costs (a) are beyond the control of Provider or required by an accrediting body, governmental agency or court order, (b) were not foreseeable at the time the annual budget was submitted to Blue Cross, (c) are adequately demonstrated by appropriate records of the Provider, and (d) the Provider takes timely remedial action to attempt to minimize any such increase in costs. A list of illustrating examples of such unanticipated costs are detailed in Exhibit D hereto.

18.4.3. In calculating the percentage change between the prior and budgeted year's inpatient costs pursuant

to subsection 18.4.2, the following adjustments shall be made: (a) all direct costs associated with the line items identified as food, fuel and utilities (excluding telephone, but not the increase arising directly from the discontinuance of the charitable allowance) in the budget forms attached as Exhibit B shall be excluded, and the increases in such costs shall be paid by the Plan without regard to the foregoing limitations on reimbursement; (b) depreciation and interest on capital items as well as all lease rentals related to real estate or capital equipment shall be excluded; (c) the budgeted interest cost attributable to borrowings for operating funds and working capital shall be recomputed at the end of each fiscal year to determine the difference between the budget and actual cost attributable solely to the variation in budgeted and actual interest rates during the year, which amount is then either added or subtracted from the budgeted cost for purposes of determining the final limitation required by subsection 18.4.2, and (d) appropriate additions or reductions shall be made to reflect medical services or facilities initiated or discontinued by the Provider so as to annualize the two periods for comparison purposes, said procedure being more fully described in Exhibit E hereto.

18.4.4. In the event the annualized percentage change in the "Hospital Cost Index", computed in accordance with the procedure described in Exhibit F hereto, exceeds the median percentile increase for all Providers calculated on either an inpatient per case or per diem basis, or on an overall total cost basis, as indicated in subsection 18.4.2, the appropriate median percentile change shall be increased to the percentage change indicated by the Hospital Cost Index multiplied by 125% plus one-half of one percent to fix a final maximum limitation on approved

inpatient reimbursement. In the event the index declines in a subsequent quarter during the fiscal year the maximum permissible percentage increase will be adjusted accordingly so that at the end of fiscal year the maximum permissible percentage increase will be determined using the greater of the median rate of increase or the actual annual change in the index during the fiscal year.

18.4.5. In the event reimbursement to the Provider is limited in any fiscal year during the term of the Agreement, the Provider may, during the three fiscal years immediately following the fiscal year such limitation applied, be reimbursed for all or a portion of such disallowed cost. In determining what portion, if any, that the Provider may recover in any year during the three year period, the Provider's actual allowable costs for each such year, on the basis selected in subsection 18.4.2, will be compared with the prior year's actual allowable cost to determine the annual percentage increase in cost, after making the adjustments required by subsection 18.4.2. If this increase in any year during the three year period is less than the median permissible increase for such year (computed in accordance with subsection 18.4.2.2), the Provider will be allowed a credit for said year (adjusted as provided in subsection 18.4.3) not to exceed the previously disallowed cost. This credit, which shall be equal to the product of (i) the percentile difference between the Provider's actual increase and the maximum permissible increase allowed all Providers in such year, and (ii) the Provider's total allowable inpatient costs, will be reimbursed to the Provider, without interest, by the Plan in the year or years earned. In the event this Agreement should terminate prior to the expiration of the three year period wherein recovery of a previous disallowance may be effected by the Provider,

any new contract or agreement between the Plan and Provider applicable during such three year period shall incorporate this subsection 18.4.5 by reference.

18.4.6. The initial percentage limitation required by subsection 18.4 shall be computed to the nearest one (0.01) hundredth of a percent but subsequent adjustments shall only be made in the event there is a change of more than one (0.1) tenth of a percent.

Exhibit D

Unanticipated Costs

The following is a list of those items which would generally be considered as an unanticipated cost for purposes of subsection 18.4.2.4 and thus require revision in the inpatient rate:

1. Imposition of real estate or other tax levies not currently projected or presently in effect. This would mean that if real estate taxes were assessed against non-profit hospitals such would require adjustment although the increase in F.I.C.A. taxes would not since they are already known changes which will affect all hospitals and be reflected in the median increase.

2. Unforeseen changes in Federal, state or local statutes, administrative or judicial decisions or regulations which adversely affect expenses, such as pension plan insurance, new pension vesting requirements, environmental or safety standards.

3. Natural catastrophes, civil insurrection or other occurrence, resulting in substantial physical damage to the hospital's physical plant which adversely affects traditional patterns of patient care.

4. Prolonged failure of major equipment which has a material effect on the hospital's ability to provide its customary and historical patient services.

5. Identifiable expenditures required in order to maintain accreditation due to changes in the accrediting body's standards.

The following list is illustrative of the type of occurrences which would *not* qualify for exception under Subsection 18.4.2.4 contemplated above:

1. Low occupancy or underutilization of a department, facility or service.

2. Underutilization of supportive or ancillary services.

3. Failure to comply with planning agency recommendations pursuant to Section 24 in a timely manner.

4. Maintenance of excessive facilities or staffing levels resulting in abnormal capital or wage costs.

EXHIBIT E

Annualization Adjustments

Subsection 18.4.3 requires that in determining the percentage cost increase that a Provider experiences in a given fiscal year over a prior year, appropriate adjustments will be made in the base year to reflect changes in services or facilities so as to normalize the two periods for purposes of making the calculation. For example, any change in the Provider's services or facilities which requires the approval of the Hospital Survey Committee, Inc. (HSC), as detailed in Section 24 of the 1971 Hospital Agreement and modified by the 1973 Summary of

Principles, must be identified separately in the Provider's budget and adjustment therefor made in the calculation of the annual percentage increase attributable inpatient costs.

Annualization adjustments will be made employing generally accepted accounting procedures and Medicare guidelines, as appropriate.

EXHIBIT F

Hospital Cost Index

The Hospital Cost Index (HCI) referred to in subsection 18.4.4 will be calculated at the end of each calendar quarter by the Plan, which calculation shall then be verified by the Joint Provider-Plan Committee. To the extent the HCI produces a percentile price change which is greater than the median percentile increase for all Providers (calculated as indicated in subsection 18.4.2) the maximum permissible percentage increase will be increased as provided in subsection 18.4.4.

The HCI is designed to encompass all things that area hospitals purchase except for those items specifically identified in subsection 18.4.3(a) and 18.4.3(b). The HCI measures the price change in each such item as compared with the prior fiscal year to determine an annual rate of increase. The various labor and non-labor cost categories which comprise the HCI are set forth in the following table together with the index which will be used in measuring the change in that cost, as well as the weight, expressed as a percentage that will be attributed to each such category in calculating the HCI.

SOURCES OF WAGES AND PRICE INDEXES

	Labor Categories	*Name of Index*	*Source*	*Weighting (%)*
A	Administration	"Insurance" Wage Rate	#63, Table C-2, *Empl. & Earn.*	
B	Clerical	"Insurance" Wage Rate	#63, Table C-2, *Empl. & Earn.*	
C	Nursing	"Hospitals" Wage Rate	#806, Table C-2, *Empl. & Earn.*	
D	Technical	"Services" Wage Rate	Table C-2, *Empl. & Earn.*	
E	Housekeeping, Kitchen, Aids	"Hotels" Wage Rate	#702, Table C-2, *Empl. & Earn.*	
F	Professional	"Hospitals" Wage Rate	#806, Table C-2, *Empl. & Earn.*	
G	Skilled	"Services" Wage Rate	Table C-2, *Empl. & Earn.*	
	Non-Labor Categories			
H	Medical & Surgical Equipment & Disposables	(.2)-Misc. Rubber Products	#07-13, WPI, *Monthly Labor Review*	
		+(.7)-Unsupported Plastic Film & Sheeting	#07-22, WPI, *Monthly Labor Review*	
I	Drugs	Drugs and Pharmaceuticals	#06-3, WPI, *Monthly Labor Review*	

	Non-Labor Categories	*Name of Index*	*Source*	*Weighting (%)*
J	Linens and Wearing Apparel	Sheets	CPI, *Monthly Labor Review*	
K	Office Supplies	Paper	#09-13, WPI, *Monthly Labor Review*	
L	Paper & Disposables	Sanitary Paper Products	SJC Code 2647, Table 32, *Monthly Labor Review*	
M	Chemicals	Industrial Chemicals	#06-1, WPI, *Monthly Labor Review*	
N	Kitchen & Housekeeping Supplies	(.5) Laundry, Soap, Detergent	CPI, *Monthly Labor Review*	
		+(.25)-Dinnerware	CPI, *Monthly Labor Review*	
		+(.25)-Flatware	CPI, *Monthly Labor Review*	
O	Maintenance Supplies	+(.5)-Prepared Paints	#06-21, WPI, *Monthly Labor Review*	
		(.5)-Paint Materials	#06-22, WPI, *Monthly Labor Review*	
P	Laundry	Laundry, Flatware	CPI, *Monthly Labor Review*	
Q	Insurance	Property Insurance Premiums	CPI, *Monthly Labor Review*	

Exhibit 25

Annex D

GUIDELINES FOR A SHORT PROCEDURE UNIT

1. The Short Procedure Unit (SPU) is a segregated facility established by a Provider for the performance of therapeutic and diagnostic procedures that (i) cannot safely or appropriately be accomplished on a conventional out-patient basis, (ii) are best done in a hospital setting, and (iii) are usually completed within an eight-hour period without requiring an overnight stay in the hospital. Exceptions to the foregoing eight-hour limit may be made as justified on a case-by-case basis.

2. The procedures to be performed in the SPU are usually those that can be scheduled in advance by the attending physician, but after which the patient cannot be discharged without a limited post-procedure observation period.

Some examples of the procedures which are customarily performed in the SPU are:

Multiple x-ray studies

Endoscopic procedures

D & C's and D & E's

Transfusions

Certain chemotherapeutic procedures

Angiograms

A wide range of minor surgical procedures, especially those requiring general anesthesia and observation of patient for a period of time following the procedure.

3. The volume of procedures necessary to justify a SPU should require a minimum of four designated beds for post-procedure recovery (which may be used for

Exhibit 25

other purposes in the event of insufficient SPU procedures) and an appropriate staffing.

4. The SPU should include professional and administrative control and supervision to assure appropriate utilization so that patients are not admitted who could be appropriately cared for on a conventional out-patient basis.

5. The Plan will provide benefits to Subscribers receiving care in a SPU as if they were inpatients, but reimbursement will be made as if the SPU care were rendered on an out-patient basis.

6. Routine service charges in the SPU may not exceed the hospital daily service charge for the most prevalent semi-private accommodations for one day.

7. Appropriate material shall be developed by the Provider for the information of its medical staff concerning utilization and scheduling as well as brochures for distribution to patients who will be cared for in the unit.

8. The Joint Provider-Plan Committee shall from time to time review the utilization review standards and minimal requirements encompassing the above, which shall be subscribed to by the hospitals as a prerequisite to any grant payments with regard to the SPU.

Exhibit 28

Pennsylvania Act of August 2, 1975 (No. 94)
(appended to Jurisdictional Statement)

Exhibit 29

SCHNADER, HARRISON, SEGAL & LEWIS

(Letterhead)

July 8, 1975

Honorable William A. Shephard
Insurance Commissioner
Insurance Department
Finance Building—Room 108
Harrisburg, PA. 17120

Dear Commissioner Shephard:

At our meeting on July 3, 1975, Governor Shapp asked us to put in writing what we consider to be the remaining issues and to state our position on each of them.

DVHC believes the remaining issues are as follows:

1. *Unreimbursed Patient Care and Operating Growth Need*

We will accept annually 7½% based on the total Blue Cross reimbursable costs of Provider which shall be paid to the Delaware Valley Hospital Council and distributed by it among the Providers.

2. *Areawide Planning of Health Care Facilities*

Provider shall comply with PL 92-603 § 1122 and applicable sections of PL 93-641 when implemented. We do not object to the "B" Agency, or whatever agency is empowered under the law contracting with the Hospital Survey Committee to perform functions required by law. However, only the final decisions made by the planning agency designated by law will be binding on the parties.

3. *Term of Agreement*

We will agree to a firm two (2) year contract terminating on June 30, 1977, with neither party having the

right to terminate the agreement during the two (2) year period. However, we will not agree to any run-out period after June 30, 1977.

4. *Retroactivity*

We believe that any agreement has to be retroactive to July 1, 1974.

During the retroactive period Providers will be reimbursed their total Blue Cross reimbursable costs based generally on the 1971 Agreement as modified by the 1973 Agreement of Principles and recent negotiations, and with no ceilings or Medicare cost limitations of any kind.

We would agree to your suggestion to give Blue Cross credit for money paid to Subscribers where Blue Cross has paid non-member benefits on a per diem basis, but if Blue Cross has paid full charges to a patient, we will not give Blue Cross credit for the amount in excess of reimbursable cost. Providers will actively pursue collection procedure against those patients who did not pay Provider the money received from Blue Cross.

We believe that we have reached agreement on the other items. However, we cannot be sure until we attempt to put the other items into contract form.

Sincerely yours,

/s/ FRANK H. ABBOTT

Frank H. Abbott, Attorney
for Delaware Valley
Hospital Council

(As Presented by DVHC Negotiators at Mediation Session with Governor Shapp on August 1, 1975)

ADDENDUM TO DVHC'S PROPOSED AGREEMENT DATED JUNE 10, 1975

The attached proposed agreement was discussed with Blue Cross and the Insurance Department on June 12, 1975. The Hospitals resubmit the proposed agreement subject to the following changes:

Section 3. Utilization Review. Each Provider will continue to use its present UR method as long as Blue Cross uses its present enforcement procedure until the new Medicare regulations are implemented.

Section 5.3.2 and 5.3.3 of the 1971 agreement would be reinserted since some Providers do have wards.

The first paragraph of Section 7 of the 1971 agreement shall be reinserted.

Section 20—Appeals Procedure—Abbott and Stewart shall agree upon a general appeals procedure which shall provide for immediate judicial proceedings unless the parties immediately select an arbitrator or arbitration board to hear the dispute and render a binding decision.

Section 21—Term of Agreement shall be from July 1, 1975 to and including June 30, 1977 with neither party having the right to terminate the agreement during the two (2) year period. There shall be no run-out period after June 30, 1977.

The agreement would be retroactive to July 1, 1974. During the retroactive period Providers will be reimbursed their total Blue Cross reimbursable costs based on the 1971 agreement as modified by the 1973 Agreement of Principles, the Media Court settlement and recent negotiations with no ceilings or Medicare cost limitations of any kind. Providers would agree to give Blue Cross credit for money paid to Subscribers where Blue Cross has paid non-member benefits on a per diem basis, but if

Exhibit 29

Blue Cross has paid full charges to a patient, Providers will not give Blue Cross credit for the amount in excess of the Blue Cross reimbursable cost. Providers will actively pursue collection procedure against those patients who did not pay Provider the money received from Blue Cross. Blue Cross will provide Provider with a list of all Subscribers and their dependents who received Covered Services indicating the amount of money paid to the Subscriber or the dependent and if the Subscriber has not paid Provider, Blue Cross will notify each such Subscriber that they are expected to make such payment.

Blue Cross will identify total non-contract inpatient days of service multiplied by the current per diem rate, deduct from it the total dollars paid by Blue Cross to the Subscribers and pay the balance to the Provider within thirty (30) days from the execution of an agreement as an interim payment to be adjusted on final audit.

Exhibit "A" attached to the Provider's proposed agreement shall be deleted and in lieu thereof, Providers will be reimbursed their total Blue Cross reimbursable cost based on the 1971 Agreement as modified by the 1973 Agreement of Principles, the Media Court Settlement and recent negotiations with no ceilings or Medicare cost limitations of any kind. In addition, Blue Cross will pay quarterly an agreed upon percentage based on the total Blue Cross reimbursable cost of each Provider as determined herein, to the Delaware Valley Hospital Council and distributed by DVHC among the Providers as determined solely by the Delaware Valley Hospital Council.

During the term of the agreement the Government shall sponsor and pay for a commission to study the DVHC proposed formula or method of reimbursement as set forth in our original Exhibit "A".

Exhibit "B" shall remain as proposed, except that the appeals procedure in the event the RRC members can-

Exhibit 29

not agree on a majority decision as to the establishment of the interim rate, the matter shall be referred to the Insurance Commissioner who shall decide which of the two suggested interim rates shall apply. Until the Insurance Commissioner decides, the rate established by the DVHC representatives shall be paid by Blue Cross. If either party disagrees with the Insurance Commissioner's decision, it shall have the right to appeal that decision through the Appeals Procedure.

Exhibit 30

PROCEDURES UTILIZED IN REVIEW OF BUDGETS AND THE ESTABLISHMENT OF INTERIM RATES

SUBMISSION OF BUDGETS—Providers should submit detailed annual budgets for the purpose of prospectively establishing interim inpatient reimbursement rates for each fiscal year. The budget must be submitted forty-five days prior to the beginning of the provider's fiscal year and have prior approval of the provider's budgetary committee.

BUDGET FORMS—Budgets must be submitted on standard forms which were designed jointly by the hospitals and Blue Cross at the time of the development of the 1971 Hospital Agreement. The forms provide necessary information in sufficient detail for a comprehensive analysis of budgeted costs, toward the establishment of reasonable and accurate interim rates. The information is supplied for a three year period; the most recent year for which complete actual experience is available, the current year consisting of approximately ten months actual and two months projected, and the budget for the subsequent year. Expenses are categorized into four main divisions:

1. Salaries and Wages
2. Supplies and Expense
3. Depreciation
4. Interest of Indebtedness

Each of the main divisions are further refined to provide the detail for analysis.

Salaries and Wages—These expenses are divided into both the individual general service departments such

Exhibit 30

as the administration and overhead, as well as the direct patient care departments such as nursing service and the separate ancillary services. For each of the three years the expense is identified with the applicable number of full time employees and the number of paid hours.

Supplies and Expenses—These expenses are also divided as above. Additionally, expenses of a non-departmental nature are provided such as payroll taxes, insurance, and the separate employee fringe benefits.

Depreciation—The expense is detailed by asset classification and by the method used in computing the depreciation.

Interest—The expense is sub-divided into two categories, as interest related to either capital indebtedness or working capital indebtedness.

The forms also provide the mechanism for the establishment of the interim rate utilizing the detailed expenses. Non-allowable costs that are unrelated to patient care are listed in detail and then deducted from the total expenses. Based on actual experience, the inpatient portion of the expenses are determined and when divided by the inpatient days the inpatient interim rate is established.

In order to provide a comprehensive base for accurate comparisons and review, several supplementary questionnaire forms are required. These include a review of the personnel policies and general subjects as:

1. Participation in professional or general services.
2. Status of Cost Filings with Third Parties.
3. Service Contracts.

4. Detail of Rentals and Leases.

5. New facilities or programs.

6. Hospital based ancillary services which bill separately.

A separate form is required for medical educational expenses including the salaries, fringes, and supplies of the interns, residents, and other related personnel. This is used in computing the contractual limitation of the medical education costs. Lastly, for purposes of statistical comparison, a departmental expense summary with statistical and per diem comparison is required.

BUDGET DESK REVIEW PROCEDURE—The initial step in the review of the budget is a general and mathematical check. This is performed uniformly with established procedure for each budget submitted and includes the following:

1. Verification that all forms have been submitted and are complete.

2. Total expenses for the *actual* fiscal year are traced to the appropriate Medicare and Blue Cross cost reports to guarantee that the budget is prepared consistent with actual experience.

3. All amounts appearing on inter-related schedules are cross referenced to assure that they are reported in a consistent manner.

4. Footing and Cross Footing of all schedules to assure that the mathematics are correct.

5. Mathematical Review of all calculations which require multiplication or division.

This review is performed following a prescribed format. Each step completed in accordance with written instructions is accounted for through a check list to assure the completeness of the review.

PROFESSIONAL REVIEW OF BUDGET—This part of the budget review is considered of greatest importance as it provides the analysis necessary to assure reasonableness and justification of the rate to be established. The procedures are varied, related to all aspects of the budgets, detailed as follows:

1. Utilizing the *actual* fiscal year costs submitted on the budget, a comparison is made to assure that proper non-allowable costs have been accurately eliminated in preparing the budgeted year. Both direct and indirect costs associated with the non-allowable cost centers must be deducted from total expenses. Amounts deducted in the budgeted year should be of the same proportion as the actual year, unless a change in the service has been identified. All revenues including restricted grants that were a reduction of expenses in the actual year should likewise be reflected as reductions in the budgeted year.

2. The final Blue Cross cost report settlement is reviewed to determine the effect of audit adjustments made as a result of the audit by the independent public accounting firm. All audit adjustments of a reoccurring nature should be reflected proportionately in the budgeted year as a reduction of total expenses. In the actual year the percent of audit adjustments to total expenses is computed and then applied to the total budgeted expenses.

3. The percentage used in determining the split of budgeted inpatient and outpatient costs is com-

pared to actual experience. If it is not the same, further review is made to justify the variance, including the statistics related to the change in inpatient days and ancillary utilization and outpatient services.

4. Budgeted inpatient days are reviewed for reasonableness. Any changes from actual experience must be justified. Consideration is made as to the accuracy of previous budgets to determine if there has been a consistent trend in inaccurately forecasting the days.

In addition to the review of total expenses and the resulting interim per diem rate, careful analysis is performed on the expenses as detailed by department to determine any large increases inconsistent with the increase in total expenses. The review is made by each of the four main category of expenses.

1. *Salaries and Wages*—The percentage increase in salaries is calculated for each cost center for the three years submitted on the budgets. Justification is required for any increases above the average. The salary for each full time equivalent employee is also computed and reviewed for reasonableness. Comparison is made to assure that based on previous experience the hospital is not overbudgeting the employees based on approved open positions when in reality the full complement is never attained. Salaries are also reviewed when possible to comparable positions in hospitals in the same local area.

2. *Supplies and Expenses*—Percentage increases are also calculated in the same manner as the above salaries. Increases are reviewed on a total cost basis as well as a per diem basis. Additionally certain department costs are reviewed based on the statistics related to the specific department. For example,

dietary would be reviewed on the cost per meal; operating room on the number of operations; housekeeping on the number of square feet, etc. In every instance, if the analysis reveals items at large variance with the average of that hospital or similar hospitals, justification is required before the costs are recognized.

3. *Depreciation*—Analysis based on the detail submitted is required to assure that a uniform method of depreciation is applied in each year. Under the current Blue Cross contracts the straight line method is mandatory. Any significant increases in depreciation would be the result of improvements in the facilities or purchase of equipment. This must be verified with the hospital if the budget does not indicate the nature and amount.

4. *Interest*—Capital indebtedness interest should be decreasing each year unless additional loans for the purchases of depreciable assets are made. This expense must be correlated with the depreciation detail to determine the accuracy and reasonableness of the projections. Working capital interest will be reviewed for any significant changes. Justification could be requested from the hospital through review of budgeted income statements to determine the working capital projections and the need for borrowing. Consideration must also be given to the interest rates and future economic projections.

Finally, the budget is reviewed to determine any new or material changes in services or facilities. The hospital should disclose this detail as part of the budget submission. An in-depth analysis (usually requiring additional documentation from the hospital) is performed on such

Exhibit 30

costs including the verification of approval of outside agencies if required and the methodology utilized in establishing the cost estimate. These estimates must reflect whenever possible the trends and past experience of the individual hospital. Only accurate and reasonable estimates are approved for inclusion in the overall operating budget.

Exhibit 31

ACTUAL AND PROJECTED PER DIEM HOSPITAL COSTS IN PHILADELPHIA

Calendar Years 1964-1977

1964	$ 29.27	
1965	$ 31.56	
1966	$ 36.31	
1967	$ 41.77	
1968	$ 49.99	
1969	$ 63.11	
1970	$ 73.70	
1971	$ 83.23	
1972	$ 92.98	
1973	$103.07	
1974	$117.84	
1975	$141.88	(estimate)
1976	$170.26	(estimate)
1977	$201.25	(estimate)

Exhibit 32

OUTPATIENT CASES
PER 1,000 SUBSCRIBERS

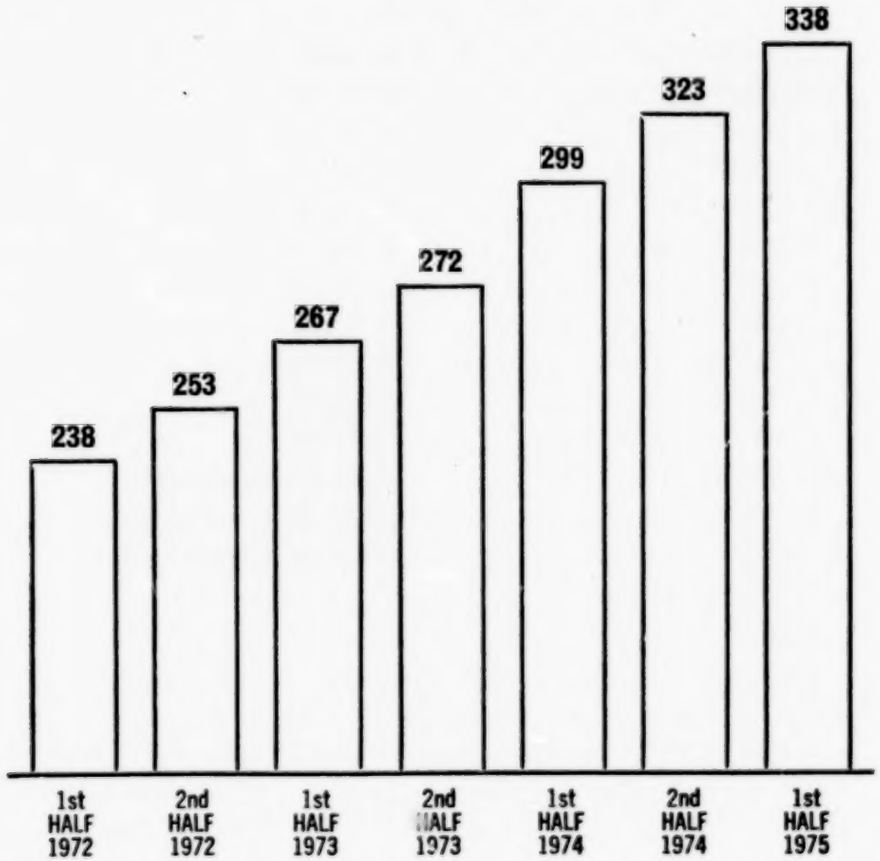
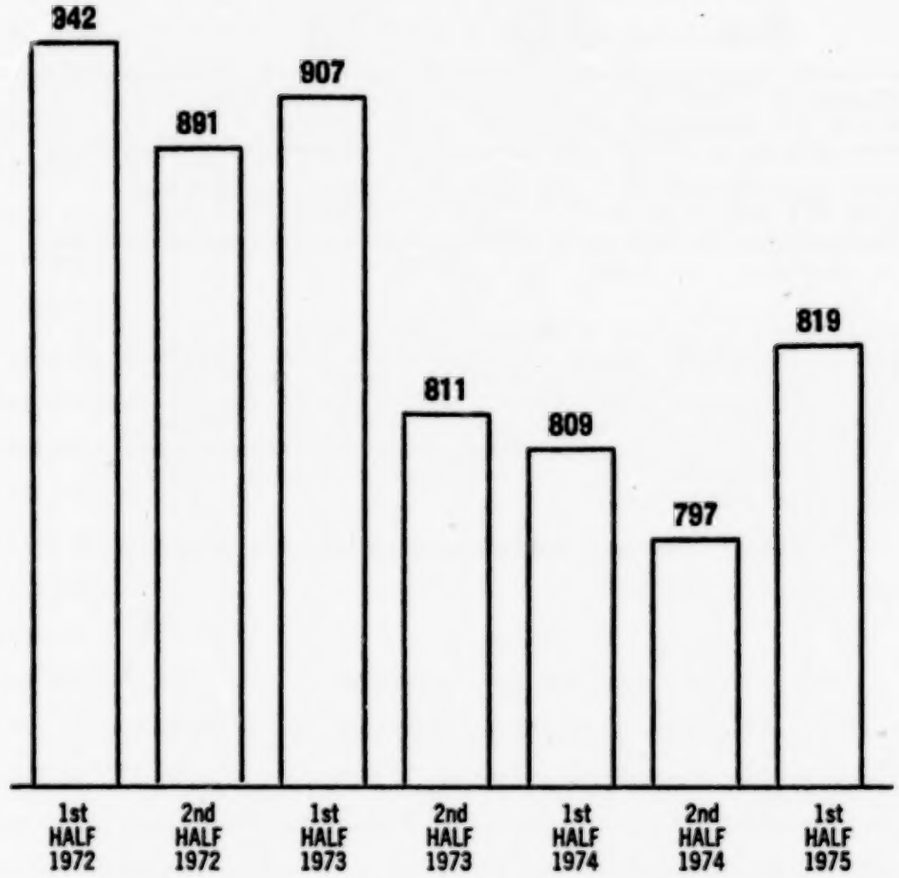


Exhibit 32

INPATIENT DAYS FOR
EACH 1,000 SUBSCRIBERS



PRIOR PRINTER'S NO. 10 Printer's No. 978

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 10 Session of 1975

INTRODUCED BY COPPERSMITH, FEIBMAN, DOUGHERTY, MURRAY, LEWIS, NOLAN AND MESSINGER, JANUARY 7, 1975

SENATOR COPPERSMITH, PUBLIC HEALTH AND WELFARE, AS AMENDED, JUNE 24, 1975

AN ACT

Relating to health care, prescribing the powers and duties of the Department of Health, establishing and providing the powers and duties of the ~~Health Care Policy Board~~ STATEWIDE HEALTH COORDINATING COUNCIL; providing for licensure, rate approval, certification of need of health care providers; creating a health advocate; ~~and the Deputy Secretary for Health Care Facilities~~ prescribing penalties; and making an appropriation. <-- <--

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

ARTICLE I

Preliminary Provisions

Section 101. Short Title.--This act shall be known and may be cited as the "Comprehensive Health Care Act."

Section 102. Purposes.--The General Assembly finds as a fact that the continuously increasing cost of health care services threatens the health and welfare of citizens of the Commonwealth by impairing the ability of citizens to obtain high quality, economical and readily available health care. The General Assembly also finds that the health and welfare of Pennsylvania citizens will be enhanced by the orderly and economical

distribution of health care resources. To achieve such distribution of resources requires governmental intervention to insure the development and organization of a coordinated and comprehensive system of health care. The goal of such a system is to enhance the public health and welfare by insuring that needed health care is available to everyone at a fair and reasonable cost; that the health care delivery system is responsive and adequate to the needs of all citizens; that health care services and facilities are most efficiently and effectively used; that consumers have meaningful input regarding the delivery of care; that health care cost inflation is limited; that unnecessary duplication, fragmentation, and dehumanization of health care services and facilities are minimized; that health care services and facilities meet high quality standards; that relevant information on the cost and quality of health care is disclosed to the public to the maximum extent possible; and, that all citizens receive humane, courteous and dignified treatment. In developing such a coordinated and comprehensive health care system, it is the policy of the Commonwealth to foster responsible private operation and ownership of health care facilities, to encourage innovation and continuous development of improved methods of health care and to aid efficient and effective planning using local agencies.

Section 103. Definitions.--As used in this act:

"ACT" MEANS THE COMPREHENSIVE HEALTH CARE ACT. <--

"Consumer" means a natural person who uses or potentially will use the services of a provider of health care, provided, however, that the consumer is not any of the following: a provider of health care; an administrator, employee or

representative of a provider of health care, an administrator, employee or representative of a third party payor as defined in this act; a member of the governing board of a provider or a third party payor, unless serving on such board as a designated consumer representative; ~~or~~ a person with a substantial financial interest in a provider, a third party payor or a major vendor of goods and services to providers or third party payors; OR A MEMBER OF THE HEALING ARTS.

"COUNCIL" MEANS THE STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED PURSUANT TO FEDERAL PUB.L.93-641.

"Department" means the Department of Health.

"Health care facility" means a general, tuberculosis, mental, chronic disease or other type of hospital, except a Federal facility or State mental hospital; an ambulatory surgical center; a physical rehabilitation facility; a skilled or intermediate care nursing facility; a radiology laboratory; a renal dialysis center; a diagnostic center; OR a home health care agency; ~~or a clinical laboratory;~~ regardless of whether such health care facility is for-profit, nonprofit or governmental; but not an office used exclusively for the private practice of the healing arts or a program which renders treatment or care for drug or alcohol abuse or dependence unless located within a health care facility or a facility providing treatment solely on the basis of prayer or spiritual means. ~~A health care facility, as defined, which is conducted by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of a religious denomination, is included for the purpose of licensure only.~~

"Health care provider" means a person who operates a health

care facility.

"Local agency" means any area-wide comprehensive health planning agency qualified under Federal Public Law 89-749 or ~~where no such agency exists, any consumer controlled regional health planning agency recognized as the exclusive planning agency by the department.~~ A SUCCESSOR AGENCY QUALIFIED UNDER FEDERAL PUB.L.93-641 OR SUBSEQUENT FEDERAL LAW.

"Person" means a natural person, corporation, partnership, association, the Commonwealth and any local governmental unit, authority and agency thereof.

"Policy Board" OR "BOARD" means the Health Care Policy Board created under the provisions of section 301.

"Rates" mean all moneys payable to providers for health care services, including fees, charges, and cost reimbursement.

"Secretary" means the Secretary of the Department of Health of the Commonwealth of Pennsylvania.

"Third party payor" means: (i) any stock or mutual insurance company, association or exchange issuing or servicing any hospitalization, accident and health, or major medical insurance policy; (ii) any hospital plan corporation, as defined in ~~the act of November 15, 1972 (P.L.1063, No.271);~~ 40 PA.C.S. § 6101 (RELATING TO DEFINITIONS); (iii) any professional health service corporation, as defined in ~~the act of November 15, 1972 (P.L.1063, No.271);~~ ~~or~~ 40 PA.C.S. § 6101; or (iv) THE COMMONWEALTH, WITH RESPECT TO PAYMENTS MADE TO HEALTH CARE PROVIDERS PURSUANT TO TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT; OR (V) any person, partnership, corporation, joint venture or other association which administers the provision of health care services on a prepaid basis; or which administers reimbursements for the provision of health care services

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DELIVERED by any health care provider or health care facility subject to the provisions of this act.

ARTICLE II

Powers and Duties of the Department

Section 201. Powers and Duties of the Department.--The department shall have the power and its duties shall be:

(1) To issue licenses to health care providers qualified under the provisions of this act and to renew, suspend, and revoke licenses.

(2) To issue and ~~renew certificates of need and amended or supplemental~~ AMEND certificates of need whenever it finds that the applicants qualify therefor under the provisions of this act. ~~and to revoke, limit or modify certificates of need held by health care providers in accordance with this act.~~

(3) To approve rates to be paid to ~~health care~~ HOSPITAL providers and to approve contracts between ~~health care~~ HOSPITAL providers and third party CONTRACT payors.

(4) To conduct, EITHER DIRECTLY OR BY CONTRACTING WITH OTHER QUALIFIED AND EXPERIENCED PERSONS, inspections, investigations, audits, inquiries and hearings on matters relating to health care facilities or services, and such related matters as may be necessary to carry out the purposes and provisions of this act.

(5) To research and, AFTER ADOPTION BY THE COUNCIL, publish annually a report on the regulation of health care facilities in Pennsylvania and ~~in conjunction with the local agency develop, publish and periodically update a long-range plan for a coordinated comprehencive Pennsylvania health care system.~~ TO RESEARCH AND PREPARE ANNUALLY A PRELIMINARY STATE HEALTH PLAN FOR PENNSYLVANIA AND IN CONJUNCTION WITH THE COUNCIL PUBLISH A STATE HEALTH PLAN FOR PENNSYLVANIA.

(6) With respect to health care facilities to investigate, and report to the Auditor General, upon every application to the Auditor General made by any institution, corporation, or unincorporated association, desiring to give a mortgage under the provisions of the act of April 29, 1915 (P.L.201, No.112), entitled "An act making mortgages, given by benevolent, charitable, philanthropic, educational, and eleemosynary institutions, corporations, or unincorporated associations, for permanent improvements and refunding purposes, prior liens to the liens of the Commonwealth for the appropriation of moneys; providing a method for the giving of such mortgages, and fixing the duties of the Auditor General and Board of Public Charities in connection therewith."

(7) To furnish such staff support and expertise to the ~~Policy Board~~ COUNCIL as may be needed by them to perform their responsibilities.

(8) To minimize the administrative burden on health care providers by eliminating unnecessary duplication of financial and operational reports and to the extent possible coordinating reviews and inspections performed by Federal, State, local and private agencies.

(9) To furnish consultation and advice to health care providers relating to financial planning and the securing of capital funds for the purchase, acquisition or construction of health care facilities.

(10) To ~~make~~ SET reasonable ~~assessments against~~ FEES TO BE PAID BY providers ~~for the cost of conducting the inspection for licensure.~~ IN CONNECTION WITH APPLICATIONS, RENEWALS, FILINGS AND PETITIONS AUTHORIZED BY THE ACT.

(11) To hold formal hearings in accordance with the act of

June 4, 1945 (P.L.1388, No.442), known as the "Administrative Agency Law" and informal hearings, conferences and other oral proceedings and receive written comments, sworn affidavits and other writings on matters for decision by the department.

(12) To designate the local agency for purposes of certification of need and to contract with such local agencies for reimbursement by the department for conducting such certification.

(13) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL REGULATIONS FOR LICENSURE AND THE PROCEDURES TO BE FOLLOWED IN ACCORDANCE WITH THE ACT. <--

(14) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL REGULATIONS FOR CERTIFICATION OF NEED AND THE PROCEDURES TO BE FOLLOWED IN ACCORDANCE WITH THE ACT.

(15) TO GRANT WAIVERS FROM RULES AND REGULATIONS WHEN FOUND TO BE IN THE PUBLIC INTEREST AND CONSISTENT WITH THE PURPOSES OF THE ACT.

(16) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL REGULATIONS FOR APPROVAL OF RATES AND CONTRACTS AND THE PROCEDURES TO BE FOLLOWED IN ACCORDANCE WITH THE ACT.

(17) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL RULES AND REGULATIONS REGARDING UNIFORM SYSTEMS OF ACCOUNTING AND REPORTING.

(18) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL RULES AND REGULATIONS IN REGARD TO DISCLOSURE OF THE CONTRACTS OF OTHER FINANCIAL ARRANGEMENTS BETWEEN HEALTH CARE PROVIDERS AND HOSPITAL BASED MEDICAL SPECIALISTS PURSUANT TO SECTION 608.

(19) TO ADOPT OTHER REGULATIONS NECESSARY OR CONVENIENT TO CARRY OUT THE PURPOSES AND PROVISIONS OF THE ACT.

~~(13)~~ (20) To implement a system of monitoring and evaluation <--

by the department of the efficiency and effectiveness of its own operations and to report the results annually to the Governor, the General Assembly and the Policy Board.

~~(14)~~ (21) To enforce the rules and regulations adopted by the ~~Policy Board.~~ DEPARTMENT. <--

~~(15)~~ (22) To exercise all other powers which are reasonably related to the effective implementation of this act. <--

ARTICLE III

~~Organization and Powers and Duties of the Health Care Policy Board, Council on Resources, the Health Advocate, and the Deputy Secretary for Health Care Facilities~~ <--

~~Section 301. Health Care Policy Board.--The Policy Board shall consist of eleven members, ten of whom shall be appointed by the Governor, and the Secretary of Health or, upon his designation, the Deputy Secretary for Health Care Facilities. Of the members first appointed, two shall be appointed for a term of one year, three for a term of two years, two for a term of three years and three for a term of four years. Thereafter, appointments shall be made for four-year terms. A vacancy occurring during a term shall be filled for the unexpired term. The members of the Policy Board shall be chosen for their training, experience and familiarity with the delivery of health care or for other ability and experience which will materially add to the deliberations of the board. Of the ten members appointed to the board, six shall be consumers and four shall be providers or third-party payors. The Governor shall have the power to designate the chairman and adjust the composition of the board to meet changing requirements of Federal statutes and regulations. Six members shall constitute a quorum.~~

~~No member may participate in any action or decision concerning any matter in which the member has a substantial economic interest.~~

~~The board may have a professional staff of such size and qualifications as the board shall determine.~~

ORGANIZATION AND POWERS AND DUTIES OF THE HEALTH CARE POLICY BOARD, STATEWIDE HEALTH COORDINATING COUNCIL AND THE HEALTH ADVOCATE <--

SECTION 301. HEALTH CARE POLICY BOARD.--THE POLICY BOARD SHALL CONSIST OF 19 MEMBERS APPOINTED BY THE GOVERNOR. OF THE MEMBERS FIRST APPOINTED, FOUR SHALL BE APPOINTED FOR A TERM OF ONE YEAR, FIVE FOR A TERM OF TWO YEARS, FIVE FOR A TERM OF THREE YEARS AND FIVE FOR A TERM OF FOUR YEARS. THEREAFTER, APPOINTMENTS SHALL BE MADE FOR FOUR-YEAR TERMS. A VACANCY OCCURRING DURING A TERM SHALL BE FILLED FOR THE UNEXPIRED TERM. THE MEMBERS OF THE POLICY BOARD SHALL BE CHOSEN FOR THEIR TRAINING, EXPERIENCE AND FAMILIARITY WITH THE DELIVERY OF HEALTH CARE OR FOR OTHER ABILITY AND EXPERIENCE WHICH WILL MATERIALLY ADD TO THE DELIBERATIONS OF THE BOARD. OF THE 19 MEMBERS APPOINTED TO THE BOARD, FOUR SHALL BE MEMBERS OF THE GENERAL PUBLIC WHO QUALIFY AS CONSUMERS, TWO SHALL BE REPRESENTATIVES OF ORGANIZED LABOR, TWO SHALL BE MEMBERS OF THE BUSINESS COMMUNITY, TWO SHALL BE THIRD PARTY CONTRACT PAYORS, ONE SHALL BE A THIRD PARTY PAYOR WHO IS NOT A THIRD PARTY CONTRACT PAYOR, ONE SHALL BE A PHYSICIAN, ONE SHALL BE A NON-PHYSICIAN MEMBER OF THE HEALING ARTS, TWO SHALL BE FROM HOSPITAL MANAGEMENT OR BOARDS, ONE SHALL BE REPRESENTATIVE OF NURSING HOMES, ONE SHALL BE A REPRESENTATIVE OF OTHER CLASSES OF PROVIDERS AND TWO SHALL BE FROM ANY CLASS OF PROVIDER. THE GOVERNOR SHALL HAVE THE POWER TO DESIGNATE THE CHAIRMAN AND ADJUST THE COMPOSITION OF THE BOARD

TO MEET CHANGING REQUIREMENTS OF FEDERAL STATUTES AND REGULATIONS. TEN MEMBERS SHALL CONSTITUTE A QUORUM.

NO MEMBER MAY PARTICIPATE IN ANY CONSULTATION, ACTION OR DECISION CONCERNING ANY MATTER IN WHICH THE MEMBER HAS A SUBSTANTIAL ECONOMIC INTEREST WITHOUT FULL DISCLOSURE OF THE NATURE AND EXTENT OF THE INTEREST.

FOR ADMINISTRATIVE PURPOSES, THE BOARD SHALL BE A COMPONENT PART OF THE COUNCIL.

Section 302. Health Care Policy Board; Powers.--The Health Care Policy Board shall have the power and its duties shall be:

(1) To review and integrate the requirements of this act and other State and Federal laws pertaining to the delivery of health care and to consult with Federal, State, local and private agencies involved in the health care system.

(2) To create such committees or advisory groups which it deems necessary to advise and make recommendations, suggestions or objections with respect to proposed regulations or to propose and recommend regulations.

(3) To annually adopt a report to the Governor, the General Assembly and the public on the regulation of health care facilities in Pennsylvania. ~~and to review and adopt a long-range plan, with periodic updates, for a coordinated comprehensive Pennsylvania health care system.~~ <--

(4) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO ADOPTION OF regulations for licensure and the procedures to be followed in accordance with this act. <--

(5) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO ADOPTION OF regulations for certification of need and the procedures to be followed in accordance with this act. <--

~~(6) To grant waivers upon the recommendation of the~~ <--

~~secretary from rules and regulations when found to be in the public interest and consistent with the purposes of this act. Whenever the secretary recommends to the Policy Board the grant of a waiver, notice of such recommendation, with a brief description of the content of the waiver sought, shall be published in the Pennsylvania Bulletin at least 30 days prior to consideration by the board. The Policy Board shall provide to any person interested as a provider, consumer or third party payor, reasonable opportunity to be heard prior to making a determination.~~

~~(7)~~ (6) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO ADOPTION OF regulations for approval of rates and contracts and the procedures to be followed in accordance with this act. <--

~~(8)~~ (7) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO THE ADOPTION OF rules and regulations regarding uniform systems of accounting and reporting. <--

~~(9)~~ (8) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO THE ADOPTION OF rules and regulations in regard to disclosure of the contracts or other financial arrangements between ~~health care~~ HOSPITAL providers and hospital based medical specialists pursuant to Section 608. <--

~~(10) To establish a schedule of reasonable fees with respect to applications, renewals, or filings to cover the department's administrative cost of processing.~~ <--

~~(11)~~ (9) To assume ALL the existing powers and duties of the Advisory Health Board in the ~~Department of Health.~~ <--

~~(12) To prescribe regulations for processes of monitoring and evaluation of the operation of providers of health care.~~

~~(13) To adopt other regulations necessary or convenient to carry out the purposes and provisions of this act.~~ DEPARTMENT <--

EXCEPT THOSE RELATING TO:

(A) VITAL STATISTICS AS SET FORTH IN SECTION 2104 OF THE ACT OF APRIL 9, 1929 (P.L.177, NO.175), KNOWN AS "THE ADMINISTRATIVE CODE OF 1929."

(B) HEALTH SERVICES FOR COUNTIES OR OTHER POLITICAL SUBDIVISIONS AS SET FORTH IN SECTION 2111(D) OF THE ACT OF APRIL 9, 1929 (P.L.177, NO.175), KNOWN AS "THE ADMINISTRATIVE CODE OF 1929."

(C) SCHOOL CHILDREN IMMUNIZATION AS SET FORTH IN SECTION 2111(C.1) OF THE ACT OF APRIL 9, 1929 (P.L.177, NO.175), KNOWN AS "THE ADMINISTRATIVE CODE OF 1929."

~~(14)~~ (10) To carry out such other responsibilities as may be conferred by this act OR REQUESTED BY THE SECRETARY. <--

Section 303. ~~Council on Resources.--(a) The council on resources shall consist of the executive committee of the Statewide Comprehensive Health Planning Council. A majority of the membership shall constitute a quorum. For purposes of this act, the Statewide Council shall elect the membership of its executive committee so as to reflect the same proportion of consumers which exists on the Statewide Council.~~

~~(b) The council on resources~~ STATEWIDE HEALTH COORDINATING COUNCIL.--(A) THE STATEWIDE HEALTH COORDINATING COUNCIL shall review and integrate the requirements of this act and State and Federal laws, rules and regulations relating to certification of need. It shall review and make recommendations, suggestions or objections to any PROPOSED rule or regulation submitted to it by the Policy Board OR THE DEPARTMENT. <--

~~(c)~~ (B) The Policy Board OR DEPARTMENT may request the council ~~on resources~~ to study and review all or any portion of the laws, rules and regulations relating to certification of

need. The council shall report to the Policy Board OR DEPARTMENT within the time prescribed. ~~by the Policy Board in making its request for the study.~~

~~(d)~~ (C) The department may assign to the council any advisory responsibilities required by Federal law or regulations pertaining to need certification of health care facilities.

Section 304. Policy Board and Council on Resources: Compensation; Expenses.--Each member of the council shall be paid traveling and other necessary expenses, and compensation at a rate to be determined by the Executive Board. The council may appoint such committees or advisory groups as it deems necessary to advise and assist it in its studies, but nonmembers of the council shall receive no compensation for services or expenses. Members of the Policy Board~~, except the secretary,~~ shall be paid traveling and other necessary expenses and compensation at a rate to be determined by the Executive Board.

Section 305. Health Advocate.--(a) There is hereby created the Health Advocate to represent the interests of users and potential users of health care services in the Commonwealth.

(b) The Health Advocate shall be appointed by the Governor for a term of four years to run concurrently with the gubernatcrial term. The compensation shall be set by the Executive Board. The Health Advocate shall possess the background, independence and judgment required to represent responsibly the interests of users and potential users of health care services.

(c) The Health Advocate shall issue an annual report to the public on the activities of the Health Advocate's office, including the types of complaints received, the results achieved pursuant to such complaints, and continuing problems.

(d) The Health Advocate shall have the power upon petition of consumers or on his own motion:

(1) to initiate or participate in formal or informal proceedings regarding any matter of the department;

(2) to ~~initiate or~~ participate in OR, UPON THE EXHAUSTION OF ADMINISTRATIVE REMEDIES, INITIATE litigation on behalf of consumers regarding health care or health related matters;

(3) to hold public hearings from time to time in various parts of the Commonwealth to solicit consumer views;

(4) to examine any relevant information and records in the possession of any Commonwealth department, board, commission or instrumentality, provided that no confidential information is disclosed or utilized in violation of law; and

(5) to publicize issues relating to matters of health care.

(e) The Health Advocate shall have authority to employ adequate professional and clerical staff and define their duties as may be necessary to carry out the powers and responsibilities imposed by this act. The salaries of the professional and clerical staff shall be set by the Executive Board. For administrative purposes the office of the Health Advocate shall be under the jurisdiction of the Governor's office.

Section 306. ~~Deputy Secretary for Health Care Facilities.--(a) There is hereby created in the Department of Health the Deputy Secretary for Health Care Facilities, who shall be appointed by the Governor and subject to the advice and consent of the Senate.~~

~~(b) The Deputy Secretary for Health Care Facilities shall be chief administrator for implementation of this act, having under his direction the functions of certification of need, licensure and rate approval. The powers, authority, duties or~~

~~responsibilities conferred by this act on the secretary or the department may, unless otherwise indicated, be exercised with equal force and effect by the Deputy Secretary for Health Care Facilities.~~ DELEGATION OF ADMINISTRATIVE RESPONSIBILITY.--THE <--
GOVERNOR MAY DELEGATE ADMINISTRATIVE RESPONSIBILITY FOR ALL OR CERTAIN PROVISIONS OF THE ACT TO ONE OR MORE DEPUTY SECRETARIES IN THE DEPARTMENT. THE POWERS AND DUTIES CONFERRED BY THE ACT ON THE SECRETARY OR DEPARTMENT MAY, UNLESS OTHERWISE INDICATED, BE EXERCISED WITH EQUAL FORCE AND EFFECT BY SUCH DEPUTY OR DEPUTIES.

ARTICLE IV

Administration of the Act

Section 401. Promulgation of Rules and Regulations.--(a) The rules and regulations under this act shall be promulgated by the ~~Policy Board~~ DEPARTMENT under the provisions of the act of July <-- <--
31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law" and shall provide fair access and due process to all interested parties in proceedings held to carry out the provisions of this act.

(b) A brief statement ~~of the reason for each substantive provision~~ AND DISCUSSION OF THE MAJOR ISSUES shall accompany <-- <--
publication of proposed regulations and subsequent changes in the Pennsylvania Bulletin, but such statement shall not have the effect of law.

Section 402. Opportunity to Be Heard.--(a) Opportunity to be heard may be granted by means of formal or informal hearings, conferences or other oral proceedings or by written comments, sworn affidavits or other writings on matters for decision by the department as may be deemed necessary by the department to make fair and informed decisions.

(b) Departmental hearings or other oral proceedings may be conducted by such persons as the secretary may designate, ~~including special agents or examiners,~~ provided that no <--
determination or order of the department shall become effective until approved and confirmed by the secretary or such representatives as he may designate for such purpose. ~~other than each special agent or examiner.~~ <--

(c) Persons conducting proceedings under this act shall have the power to subpoena witnesses, to administer oaths and examine witnesses and receive evidence in any locality which the department, having regard to the public convenience and proper discharge of its functions and duties, may designate.

(D) FORMAL HEARINGS SHALL BE CONDUCTED IN ACCORDANCE WITH <--
THE ACT OF JUNE 4, 1945 (P.L.1388, NO.442), KNOWN AS THE "ADMINISTRATIVE AGENCY LAW."

Section 403. Enforcement of Orders.--Orders of the department from which the time for appeal has expired may be enforced by the department in the court of common pleas of the county in which the health care facility is located or in the Commonwealth Court.

Section 404. Investigations and Inquiries.--Any investigation or inquiry authorized by this act shall be limited to the purposes set forth in the departmental order, rule or regulation authorizing the same.

Section 405. Appeals.--The appeal from any action of the department shall be to the Commonwealth Court.

ARTICLE V

Certificate of Need

SECTION 501. HEALTH CARE FACILITIES SUBJECT TO ARTICLE <--
V.--THIS ARTICLE SHALL APPLY ONLY TO THE FOLLOWING CLASSES OF

HEALTH CARE FACILITIES:

(1) A GENERAL TUBERCULOSIS, MENTAL, CHRONIC DISEASE OR OTHER TYPE OF HOSPITAL, EXCEPT A FEDERAL FACILITY OR STATE MENTAL HOSPITAL;

(2) A SKILLED OR INTERMEDIATE CARE NURSING FACILITY, UNLESS CONDUCTED BY A RELIGIOUS ORGANIZATION FOR THE PURPOSE OF PROVIDING CARE EXCLUSIVELY TO CLERGYMEN OR OTHER PERSONS IN A RELIGIOUS PROFESSION WHO ARE MEMBERS OF A RELIGIOUS DENOMINATION;

(3) A HOME HEALTH CARE AGENCY; OR

(4) A RENAL DIALYSIS CENTER.

Section ~~501.~~ 502. Certificate of Need Requisite for Licensure.--No license or reneval thereof to provide health care services shall be issued unless the applicant has a valid certificate of need issued by the department authorizing the use of the facility and the rendering of the services for which the license is to be issued. <--

Section ~~502.~~ 503. Certificate of Need: When Required.--(a) No person shall operate, lease OR ENTER INTO A LEASE or construct OR ENTER INTO A CONTRACT TO CONSTRUCT a health care facility without first obtaining a certificate of need from the department, authorizing such operation, lease or construction. <-- <-- <--

(b) No person operating an existing health care facility under a certificate of need shall make expenditures toward any project which will involve a total capital project cost including the fair market value of any leased property in excess of $100,000 in which he will (i) lease, erect, construct, alter, modernize or improve any building, or (ii) acquire any real property to be used now or in the future for health care purposes except by gift, devise or option, or (iii) lease or

acquire equipment. No person shall make a substantial change in services, as defined by the department, or permanently increase or decrease the bed complement beyond limits set by the department unless such person has first been authorized to do so by the department through the issuance of a new or amended certificate of need.

A HEALTH CARE PROVIDER OR LOCAL AGENCY MAY REQUEST A RULING FROM THE DEPARTMENT REGARDING THE NECESSITY OF OBTAINING A CERTIFICATE OF NEED FOR A PROPOSED CHANGE. THE DEPARTMENT SHALL MAKE SUCH RULING IN A TIMELY FASHION. <--

(c) At least 30 days prior to substantial reduction of a service or a permanent decrease in the bed complement, the provider shall notify the local agency and the department of its intended actior. If the local agency does not notify the provider of its objection within 30 days, the provider may make the specified change and an amended certificate of need will be issued automatically. If the local agency does notify the provider of its objections within 30 days, the procedures of section 504 shall apply.

~~Section 503. Changes Without Issuance of Certificate of Need or Mandated Changes of Use.--(a) A certificate of need shall not be required whenever a provider of health care services is directed to alter, modernize or improve a building or acquire equipment under a Federal or State law, rule, regulation or order, but in such event, notice of the specific changes to be made shall be given by the health care provider to the department and the local agency, and the certificate of need of such facility shall be amended accordingly.~~ <--

~~(b) When other changes are made which do not require a new or amended certificate of need, such changes must be reported to~~

~~the department and the local agency at a reasonable time before such change is made.~~

Section 504. Certificates of Need; Application; Issuance.--(a) A person desiring to obtain~~, renew~~ or amend a certificate of need shall apply ~~to the local agency, supplying to it~~ BY SENDING A LETTER OF INTENT TO THE DEPARTMENT, WHICH WILL THEN DIRECT SUCH PERSON AND THE LOCAL AGENCY IN THE MANNER TO PROCEED. SAID PERSON SHALL SUPPLY such information as is required by rules and regulations. A copy of the application shall be given to SIMULTANEOUSLY the department ~~at the same time an application is made to a~~ AND THE local agency. The local agency's recommendations or objections shall be forwarded to the department and considered by the council ~~as recourses~~ if filed with the department within 60 days of the date the applicant submitted the completed application to the local agency. Council recommendations or objections, if any, shall be filed with the department within 60 days of the receipt of a copy of the application by the department or within 15 days of the timely filing of the local agency recommendations or objections whichever shall last occur. The department shall consider recommendations or objections of the council or local agency unless they are not timely filed with the department. If not timely filed, the department shall act upon the application without the recommendations or objections. FAILURE OF THE LOCAL AGENCY TO TIMELY FILE RECOMMENDATIONS OR OBJECTIONS SHALL NOT HAVE THE EFFECT OF A POSITIVE DETERMINATION AND THE DEPARTMENT MAY EXTEND THE REVIEW PERIOD BY 30 DAYS IN ORDER TO PROVIDE ADEQUATE TIME FOR STUDY AND REVIEW OF THE PROPOSAL BY THE DEPARTMENT IN THE ABSENCE OF SUCH RECOMMENDATIONS OR OBJECTIONS. Whenever objections are timely filed, the department shall

promptly set a date for a hearing on the application. The department may on its own motion or at the request of any person hold a hearing on any application.

IF THE DEPARTMENT INTENDS TO DENY AN APPLICATION, THE APPLICANT HAS THE RIGHT TO A FORMAL HEARING IN ACCORDANCE WITH THE ACT OF JUNE 4, 1945 (P.L.1388, NO.442), KNOWN AS THE "ADMINISTRATIVE AGENCY LAW." THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF THE HEARING OFFICER SHALL BE CERTIFIED TO THE SECRETARY.

(b) The department shall act upon the application within 30 days of the recommendation of the local agency or of the council, whichever shall last occur, BUT IN NO EVENT LATER THAN 90 DAYS FROM RECEIPT OF A COMPLETED APPLICATION, by granting, amending, REMANDING or refusing the requested certificate of need or by conducting a hearing on the application. Notice of filing applications for certificates of need or amendments ~~or renewals~~ thereof under subsection (a) shall be published in the Pennsylvania Bulletin ~~and any~~ AND SHALL BE PROVIDED TO THE APPROPRIATE NEWS MEDIA SERVING THE AREA IN WHICH THE PROPOSED PROJECT WILL BE LOCATED. ANY person interested as a consumer, provider or third party payor may file objections within 30 days of publication with the department setting forth specifically the reasons therefor.

~~(c) An application for a certificate of need shall be recommended, approved and issued when:~~

~~(1) there is a community need for the facility;~~

~~(2) the necessary resources are available to operate the facility;~~

~~(3) it is a prudent use of resources considering the alternative uses for such resources considering the scope of~~

types of services to be offered and considering existing facilities in adjacent areas. Noncompliance with the State plan adopted by the Policy Board may be considered by the department as a proper basis for refusal of a certificate of need;

(4) the applicant is reasonably likely to fulfill licensure requirements;

(5) the proposed health care facility is economically feasible considering anticipated volume of care and the rates to be charged.

If the health care facility or service is to be used primarily for patients from an area larger than the immediate locality or community in which it is located, certificate of need shall not be refused on the ground that the immediate locality or community has no need for the health care facility or service and the application shall be considered in terms of need of the larger area.

The local agency may take into consideration the religious orientation of a health care provider and the community to be served; it may also take into consideration, as may be appropriate, different methodologies of treatment.

Section 505. Waiver from Rules.--If the local agency has recommended a certificate of need which has been refused by the department on the ground that the issuance of such a certificate is in violation of the rules and regulations or of the State plan, the applicant may upon recommendation by the secretary apply to the Policy Board for a waiver from the rules and regulations or plan which may be granted where there is a proven exceptional need and it is consistent with the purposes of this act. No appeal shall be allowed from the refusal of the Policy Board to grant a waiver.

Section 506. Expiration of Certificate of Need.--A certificate of need shall remain effective for a period of at least three but no more than 5 years, as determined by the board, providing the facilities and services authorized are in use. Renewal of a certificate shall be determined by the department only after review and recommendation by the local agency. Standards for renewal shall be based upon the standards for issuance of a certificate. The department may provide for simplified procedures for renewal of a certificate.

Section 507. Revocation and Amendment of Certificate of Need.--(a) The department may, upon recommendation of the local agency, after due notice to the holder thereof and upon request a hearing thereon, revoke or amend a certificate of need, having due regard for the financial burden such changes may impose, should it find that the need for the service or health care facility no longer exists in the community or is not being adequately fulfilled by the service or health care facility. The department also, upon recommendation of the local agency may withdraw a certificate of need of one health care facility as to a particular service to permit the furnishing of the same service by another health care facility applying to furnish the service if the department shall find that the transfer of service is in the interest of the best use of the facilities in the community or area, is in the public interest and that the change will provide more efficient utilization of health care services in the community or area.

(b) The Policy Board shall in cooperation with the council on resources and the local agencies develop and promulgate standards for nonrenewal or revocation of a certificate of need. In cases where nonrenewal, revocation or denial of an

~~application is contemplated, the local agency and the department shall whenever possible seek in cooperation with the provider to determine and implement a satisfactory alternative use for the facility or proposed facility.~~

(C) THE DEPARTMENT SHALL DEVELOP BY REGULATION GENERAL PRINCIPLES THAT MUST BE EMPLOYED BY THE LOCAL AGENCIES AND THE DEPARTMENT IN THE DETERMINATION OF CERTIFICATE OF NEED APPLICATIONS. THE PRINCIPLES MUST PROVIDE FOR, BUT NEED NOT BE LIMITED TO, THE FOLLOWING CONSIDERATIONS: <--

(1) THE NEED FOR HEALTH CARE SERVICES IN THE AREA AND THE REQUIREMENTS OF THE POPULATION TO BE SERVED BY THE APPLICANT.

(2) THE AVAILABILITY AND ADEQUACY OF HEALTH CARE SERVICES IN THE AREA'S EXISTING FACILITIES.

(3) THE AVAILABILITY AND ADEQUACY OF OTHER SERVICES IN THE AREA WHICH MAY SERVE AS ALTERNATIVES OR SUBSTITUTES FOR THE WHOLE OR ANY PART OF THE SERVICES TO BE PROVIDED BY THE PROPOSED FACILITY.

(4) THE POSSIBLE ECONOMIES AND IMPROVEMENT IN SERVICES THAT MAY BE DERIVED FROM OPERATION OF JOINT, COOPERATIVE, OR SHARED HEALTH CARE RESOURCES.

(5) THE DEVELOPMENT OF COMPREHENSIVE SERVICES FOR THE COMMUNITY TO BE SERVED, WHETHER DIRECTLY OR INDIRECTLY, SUCH AS BY AFFILIATION.

(6) MANAGEMENT AND FINANCIAL CAPABILITIES OF THE APPLICANT AND THE LIKELIHOOD OF FULFILLING LICENSURE REQUIREMENTS BASED ON AVAILABLE INFORMATION, WHICH SHALL INCLUDE THE HISTORY OF COMPLIANCE WITH LICENSURE STANDARDS IN OTHER HEALTH CARE FACILITIES OPERATED BY THE APPLICANT.

(7) INNOVATION IN THE DELIVERY OF HEALTH CARE SERVICES.

(8) THE INTERESTS OF A DEFINED CULTURAL, RELIGIOUS, OR

ETHNIC MINORITY IN RECEIVING CARE, PARTICULARLY LONG TERM CARE, IN AN ATMOSPHERE REFLECTIVE OF THAT CULTURAL, RELIGIOUS, OR ETHNIC HERITAGE.

(9) THE LEGITIMATE INTERESTS OF AN UNDERSERVED SECTION OF A LARGER COMMUNITY OR REGION THAT MAY HAVE SUFFICIENT HEALTH CARE RESOURCES WHEN VIEWED AS A WHOLE.

(10) THE NEED FOR A FACILITY OF SERVICES OF A NATURE THAT WILL SERVE PATIENTS FROM AN AREA LARGER THAN THE IMMEDIATE COMMUNITY IN WHICH IT IS LOCATED.

(11) THE ECONOMY OF SCALE OF THE INDIVIDUAL PROVIDER AND THE BENEFITS IN REGARD TO COSTS AND QUALITY THAT THE PROPOSED CHANGES WOULD HAVE UPON AN APPLICANT WHO IS AN EXISTING PROVIDER.

(12) THE DIFFERENCES IN THE NATURE OF CARE OR MODALITY OF TREATMENT IN PROPOSED APPLICATIONS FROM EXISTING RESOURCES WHICH MAY HOLD THE SAME LICENSE CATEGORY.

(D) THE PRINCIPLES ISSUED BY THE DEPARTMENT SHALL FURTHER PROVIDE FOR APPROVAL OF A CERTIFICATE OF NEED WHEN THE DEPARTMENT FINDS THAT THE PROPOSED ALTERATIONS, MODERNIZATIONS, IMPROVEMENTS OR ACQUISITION OF EQUIPMENT ARE REQUIRED UNDER A FEDERAL OR STATE LAW, RULE, REGULATION OR ORDER.

(E) IN EVALUATING FOR APPROVAL A CERTIFICATE OF NEED APPLICATION, THE DEPARTMENT MAY RELY UPON A FORMULA-BASED ESTIMATION OF NEED, AS CONTAINED IN THE STATE HEALTH PLAN, AS PRESUMPTIVE EVIDENCE OF THE COMMUNITY NEED FOR THE PROPOSAL UNDER SUBSECTION (C). THE APPLICANT OR OTHER INTERESTED PARTIES MAY OFFER EVIDENCE TO DEMONSTRATE THAT THE NEED IS HIGHER OR LOWER THAN THE ESTIMATE IN THE STATE HEALTH PLAN. IN MAKING ITS FINAL DETERMINATION ON WHETHER A PROPOSAL PROMOTES THE PUBLIC INTEREST, THE DEPARTMENT SHALL WEIGH, BALANCE AND CONSIDER THE

COMPLEXITIES OF EACH CASE IN LIGHT OF THE STATE HEALTH PLAN AND ITS DESCRIPTIVE AND QUANTITATIVE CRITERIA AND IN LIGHT OF ALL THE PRINCIPLES FOR DETERMINING NEED SET FORTH BY THE DEPARTMENT.

(F) APPROVAL OF A CERTIFICATE OF NEED SHALL TERMINATE 12 MONTHS AFTER THE DATE OF SUCH APPROVAL UNLESS THE APPLICANT HAS COMMENCED IMPLEMENTATION OF THE PROJECT AND IS DILIGENTLY PURSUING THE SAME TO COMPLETION AS DETERMINED BY THE DEPARTMENT. THE DEPARTMENT MAY EXTEND AN APPROVAL FOR UP TO AN ADDITIONAL 12 MONTHS FOR GOOD CAUSE SHOWN.

Section ~~508~~ 505. Appeals.--The action of the department upon an application for a certificate of need or for ~~renewal,~~ amendment ~~or revocation~~ thereof may be appealed to the Commonwealth Court by the applicant. ~~or by the local agency, having timely filed its recommendations or objections~~ Appeals shall be taken by filing notice of appeal with the Commonwealth Court within 30 days of notice of the department's action. <--

SECTION 506. IMPLEMENTATION.--THE DEPARTMENT SHALL IMPLEMENT CERTIFICATE OF NEED NO LATER THAN SIX MONTHS FROM THE EFFECTIVE DATE OF THE ACT. <--

ARTICLE VI

Licensure

Section 601. Licensure.--No person shall establish, maintain or operate a health care facility without first having obtained a license therefor issued by the department.

Section 602. Application for License.--Any person desiring to secure a license for conducting, maintaining and operating a health care facility shall submit an application therefor to the department upon forms prepared and furnished by it, containing such information as the department considers necessary to determine that the health care provider and the health care

facility meet the requirements of licensure under the provisions of this act and the rules and regulations relating to licensure. Application for renewal of a license shall be made upon forms prepared and furnished by the department and shall contain such information as may be necessary to determine whether the license should be renewed.

Section 603. Issuance of License.--(a) A health care provider to which a certificate of need has been issued, making application, shall be issued a license when the following standards have been met:

(1) that there is compliance with section ~~601~~ 502; <--

(2) that there is a compliance with the ~~departmental~~ rules and regulations pertaining to licensure ADOPTED BY THE DEPARTMENT TO CARRY OUT THE PURPOSES AND PROVISIONS OF THE ACT. <--

In developing rules and regulations for licensure the department shall take into consideration the standards of the Joint Commission on Accreditation of Hospitals, the Committee on Hospital Accreditation of the American Osteopathic Association and such other accrediting bodies as the board may find appropriate.

(b) When a health care provider operates more than one health care facility, each health care facility providing services to a different segment of the population and operating in autonomous or semi-autonomous fashion with respect to other facilities operated by the same provider shall require a separate license.

Section 604. Provisional License.--When there are numerous deficiencies or a serious specific deficiency in compliance with applicable statutes, ordinances or regulations, and when the department finds the applicant is taking appropriate steps to

correct the deficiencies in accordance with a timetable agreed upon by the department, the department may issue a provisional license for a specified period of not more than 4 SIX months <-- which may be renewed ~~twice~~ THREE TIMES at the discretion of the <-- department. Upon overall compliance, a regular license shall be issued immediately.

Section 605. Issuance of a Modified License.--When the certificate of need for a facility is amended as to services which can be offered, the department shall ~~automatically~~ issue a <-- modified license for those services contained in the amended certificate of need UPON DEMONSTRATION OF COMPLIANCE WITH <-- LICENSURE REQUIREMENTS.

Section 606. Term and Content of License.--(a) All licenses issued by the department under this act:

(1) shall expire unless renewed 4 ONE year from the day on <-- which issued, except for a provisional or modified license;

(2) shall be on a form prescribed by the department;

(3) shall not be transferable except upon prior written approval of the department;

(4) shall be issued only to the health care provider for the health care facility or facilities named in the application; and

(5) shall specify the maximum number of beds, if any, to be used for the care of patients in the facility at any one time.

(b) The license shall at all times be posted in a conspicuous place on the provider's premises. Except in case of extreme emergency, no licensee shall permit the use of beds for inpatient use in the licensed facility in excess of the maximum number set forth in the license without first obtaining written permission from the department. The department may grant temporary use of beds without a certificate of need.

(c) The department shall require reasonable public notice of a hospital or nursing home provider's application for license reneval and any person interested as a consumer, provider or third party payor may file objections within 30 days with the department setting forth specifically the reasons therefor.

Section 607. Right to Enter and Inspect.--(a) For the purpose of determining the suitability of the applicants, the premises and the operations or the continuing conformity of the licensees to this act and to applicable State and Federal regulations, any authorized agent of the department shall, upon proper identification made to the individual in charge of the health care facility, have the right to enter, visit and inspect any provider licensed or requiring a license under this act and shall have full and free access to the records of the facility reasonably related to its purpose, to the patients and employees therein, and shall have full opportunity to interview the patients and employees, giving due regard to protection of the health and sanitary conditions, confidentiality of medical information and the patients' rights to protection against violation of their privacy involved in any such interview. No inspection made hereunder shall unduly interfere with the operation of the facility. The inspection result and any violations cited by the department shall be made public by the department within a reasonable time thereafter.

(b) The department may disclose to the public or require providers to disclose to the public any data or information as may be prescribed by regulation.

Section 608. Public Disclosure by Hospital Provider.--Every hospital provider shall disclose to the public annually the contracts or other financial arrangements between such provider

and every hospital based medical specialist connected with it who charges a fee separate and distinct from the provider's rate. The disclosure shall include gross and net proceeds actually derived from the contract or arrangement by the specialist. "Hospital based medical specialist" means any person rendering a service where there is no freedom of choice, as defined by regulation, for the patient to utilize a person offering that service who is not based in or affiliated with (except by customary staff privilege granted to numerous qualified persons in separate practices) the hospital provider.

Section 609. Refusal to Issue License; Suspension; Revocation; Notice.--(a) Whenever the department, upon reasonable complaint of any person and/or in the course of any inspection or investigation of a licensed health care facility shall learn of any violation of this act or of rules or regulations relating to licensure adopted pursuant to this act, or to Federal laws or regulations, it shall give written notice thereof to the health care provider. Such notice shall require the health care provider to take specific action to bring the health care facility into compliance with this act and the rules and regulations relating to licensure within a reasonable specified time.

(b) The department may refuse to renew a license or may revoke a license as to all or portions of a health care facility for any of the following reasons:

(1) substantial, numerous or continuing violations of provisions of this act or of the regulations for licensure issued pursuant to this act or to Federal laws or regulations;

(2) fraud or deceit in obtaining or attempting to obtain a license;

(3) lending, borrowing or using the license of another, or in any way knowingly aiding or abetting the improper granting of a license;

(4) substantial or continued incompetence, negligence or misconduct in operating the health care facility or in providing services to patients;

(5) mistreating or abusing individuals cared for by the health care facility; or

(6) the operation of a health care facility or rendering of services for which a certificate of need is required under this act by a health care provider who has not obtained the requisite certificate. ~~or whose certificate has been revoked by the department.~~ <--

(c) If the department, after examination of the application for a license or the renewal of a license or upon complaint and after such investigation as it may deem advisable, determines that there are apparent reasons for refusal of the license or a renewal as to all or a portion of the health care facility, it shall give written notice to the applicant specifying the reasons for its determination. Within 30 days of such notice, the applicant may demand a hearing which the department shall promptly provide to determine whether the license or renewal should be issued. The department may suspend or revoke a license, after due notice to the licensee of the specified charges, and a right to a hearing thereon and the department shall do so immediately in cases of imminent danger to health or safety of patients. Nothing herein contained shall impair any other enforcement powers of the department.

(d) Persons interested as consumers, providers or third party payors shall be entitled to participate in any hearings

held pursuant to this section.

Section 610. Appeal to Commonwealth Court.--If the department shall refuse a license or reneval thereof or suspend or revoke ~~or modify~~ a license, AS TO ALL OR PART OF A FACILITY <-- the applicant or licensee shall be entitled tc appeal to the Commonwealth Court from the adjudication of the department within 30 days of the service of such order upon the applicant or licensee by filing a notice of appeal. Except in cases of imminent danger to health or safety of patients, no order of the department which is appealed which would terminate the right of any person to operate a health care facility already licensed shall be effective unless the department obtains from the Commonwealth Court a decision approving the enforcement of such order or the provider fails to perfect an appeal to Commonwealth Court within 30 days. Any license previously issued shall be deemed to continue in effect pending appeal notwithstanding the expiration of its term unless otherwise determined by Commonwealth Court.

Section 611. Violation; Penalty.--(a) Any person operating a health care facility within this Commonwealth without a license required by this act, shall upon conviction thereof be sentenced to pay a fine of not more than $300, and costs of prosecution and/or to undergo imprisonment for not less than ~~30~~ TEN days nor <-- more than 30 days. Each day of operating a health care facility without a license required by this act shall constitute a separate offense.

(b) Any person, regardless of whether such person is a licensee, who has committed a violation of any of the provisions of this act pertaining to licensure or of rules and regulations related to licensure shall upon conviction thereof in a summary

proceeding be sentenced to pay a fine of not more than $300, and costs of prosecution and/or to undergo imprisonment for not more than ~~30~~ TEN days: Provided, however, That the department may <-- accept a civil forfeiture in settlement of an action. Each day the violation continues shall constitute a separate offense.

(c) These provisions shall be in addition to any other enforcement powers granted under this act.

ARTICLE VII

Uniform Accounting and Reporting~~; Rate Approval~~ <--

~~Section 701. Findings and Legislative Intent.--The General Assembly finds that many health care providers, especially hospitals, are experiencing serious financial difficulties due to a system of rate payment that is a patchwork of Federal and State Governments, profit and nonprofit insurance plans, and private individuals who are sold insured or are insured at all, and also due to fragmented State responsibility for rate regulation. It is the intent of the General Assembly that the Department of Health foster sound, efficient and dynamic health care institutions and administer this act with the goal of reducing and eventually eliminating the dysfunctions in health care financing that exist today.~~

SECTION 701. HEALTH CARE FACILITIES SUBJECT TO ARTICLE VII.--UNLESS OTHERWISE SPECIFIED, THIS ARTICLE SHALL APPLY ONLY TO THE FOLLOWING CLASSES OF HEALTH CARE FACILITIES: <--

(1) A GENERAL TUBERCULOSIS, MENTAL, CHRONIC DISEASE OR OTHER TYPE OF HOSPITAL, EXCEPT A FEDERAL FACILITY OR STATE MENTAL HOSPITAL; AND

(2) A SKILLED OR INTERMEDIATE CARE NURSING FACILITY, UNLESS CONDUCTED BY A RELIGIOUS ORGANIZATION FOR THE PURPOSE OF PROVIDING CARE EXCLUSIVELY TO CLERGYMEN OR OTHER PERSONS IN A

RELIGIOUS PROFESSION WHO ARE MEMBERS OF A RELIGIOUS DENOMINATION.

Section 702. Uniform Financial Reporting.--(a) The ~~Policy Board~~ DEPARTMENT shall by rule, after consultation WITH THE BOARD and public hearings, prescribe a uniform system of financial reporting for health care providers, specifying the information to be reported and the manner of its reporting. It shall include:

(1) a balance sheet detailing all assets, liabilities and the net worth of the institution;

(2) a statement of income and expenses for the fiscal year; and

(3) such other reports as the ~~Policy Board~~ DEPARTMENT may prescribe.

(b) Every health care provider shall file with the department the required financial reports on forms provided by the department and at specified intervals but at least annually.

(c) The ~~Policy Board~~ DEPARTMENT shall require the filing of all reports by specified dates, and may adopt regulations which assess ~~penalties~~ REASONABLE LATE FILING FEES for failure to file as required.

Section 703. Uniform System of Accounting.--(a) The ~~Policy Board~~ DEPARTMENT shall by rule, after consultation WITH THE BOARD and public hearings, prescribe a uniform system of accounting for health care providers. It shall specify accounting procedures to be applied in connection with budgets, schedules of income and expenses, assets and liabilities, allocation of costs, units of service and such subjects as the department finds appropriate.

(b) ~~Beginning with a provider's fiscal year starting on or~~

~~after January 1, 1976, every health care~~ EVERY provider shall maintain A SET OF accounts in accordance with the accounting system prescribed by the ~~Policy Board~~ DEPARTMENT BEGINNING AT A TIME DETERMINED BY THE DEPARTMENT BUT NO LATER THAN TWO YEARS FROM ENACTMENT OF THE ACT. A PROVIDER MAY MAINTAIN ANOTHER SET OF ACCOUNTS FOR ITS OWN INTERNAL MANAGEMENT PURPOSES. Accounting forms will be developed and distributed by the department.

(C) THE DEPARTMENT SHALL TAKE INTO CONSIDERATION THE PRINCIPLES OF ACCOUNTING ESTABLISHED BY THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS, THE CHART OF ACCOUNTS ESTABLISHED BY THE AMERICAN HOSPITAL ASSOCIATION, AND ANY OTHER APPPOPRIATE STANDARDS UTILIZED BY HEALTH CARE PROVIDERS.

Section 704. Modifications in the Accounting and Reporting System.--The ~~Policy Board~~ DEPARTMENT may allow and provide for modifications in the accounting and reporting system in order to reflect differences between the various categories, sizes or types of health care providers.

SECTION 705. CLASSIFICATIONS OF PROVIDERS; COMPARISON OF REPORTS.--(A) THE DEPARTMENT SHALL, AFTER CONSULTATION WITH THE BOARD, DEVELOP CLASSIFICATIONS FOR HEALTH CARE PROVIDERS, BASED UPON SUCH CRITERIA AS SIZE, GEOGRAPHY, ECONOMIC FACTORS IN THE AREA, TYPE OF FACILITY, TEACHING PROGRAMS RELATED TO PATIENT CARE AND SCOPE OF SERVICES PROVIDED.

(B) THE DEPARTMENT SHALL REVIEW AND ANALYZE THE REPORTS TO BE MADE TO IT PURSUANT TO THIS ARTICLE AND SHALL DEVELOP A COST COMPARISON FOR EACH CLASS OF FACILITY SUBJECT TO THIS ARTICLE CONTAINING STATISTICAL NORMS WITH RESPECT TO SUCH ELEMENTS OF FINANCIAL OPERATIONS AS MAY BE DESIGNATED BY THE DEPARTMENT. THE COMPARISON SHALL INCLUDE THE COMPARISON OF EACH PROVIDER WITH EVERY OTHER PROVIDER WITHIN THE SAME CLASSIFICATION. THE

APPROPRIATE COMPARISON SHALL BE AVAILABLE TO THE GENERAL PUBLIC AT THE OFFICE OF THE DEPARTMENT AND OF EACH THIRD PARTY PAYOR AND AT EACH HEALTH CARE FACILITY.

(C) BASED UPON THE FINANCIAL REPORTS MADE TO IT AND THE COMPARISON, THE DEPARTMENT MAY IDENTIFY THOSE PROVIDERS WHOSE FINANCIAL OPERATIONS DEVIATE SIGNIFICANTLY FROM THE STATISTICAL NORMS OR FROM OTHER PROVIDERS WITHIN THE SAME CLASSIFICATION. THE DEPARTMENT MAY REQUIRE ANY HOSPITAL PROVIDER SO IDENTIFIED TO JUSTIFY THE REASONABLENESS OF THE DEVIATION AND, UPON FAILURE OF THE PROVIDER TO ADEQUATELY JUSTIFY, MAY REQUIRE THE ADOPTION AND IMPLEMENTATION OF AN APPROPRIATE COST CONTAINMENT PROGRAM.

(D) IF A HOSPITAL PROVIDER HAS FAILED TO JUSTIFY THE REASONABLENESS OF THE DEVIATION AND HAS FAILED OR REFUSED TO ADOPT AND IMPLEMENT THE COST CONTAINMENT PROGRAM REQUIRED BY THE DEPARTMENT, THE DEPARTMENT SHALL CONSIDER THE UNJUSTIFIED PORTION OF THE COST WHEN REVIEWING AND APPROVING THIRD PARTY CONTRACT RATES AND OTHER RATES PAID TO THAT PROVIDER.

SECTION 706. NURSING FACILITY COST REPORT.--EVERY SKILLED OR INTERMEDIATE CARE NURSING FACILITY SHALL ALSO HAVE AVAILABLE ON ITS PREMISES FOR PUBLIC INSPECTION A COPY OF THE FACILITY'S FINANCIAL REPORT REQUIRED BY THIS ARTICLE.

ARTICLE VIII

RATE APPROVAL

SECTION 801. HEALTH CARE FACILITIES SUBJECT TO ARTICLE VIII.--THIS ARTICLE SHALL APPLY ONLY TO GENERAL, TUBERCULOSIS, MENTAL, CHRONIC DISEASE OR OTHER TYPE OF HOSPITAL, EXCEPT A FEDERAL FACILITY OR STATE MENTAL HOSPITAL.

Section ~~705~~ 802. Rate Review; Timetable.--~~The rates to be paid to health care providers shall become subject to review by the department according to the following timetable:~~ <--

~~(a) Rates Paid by Third Parties.--Beginning January 1, 1976, contracts~~ (A) CONTRACTS AND CONTRACT RATES between ~~health care~~ providers and third party CONTRACT payors for the rendering of health care services~~, including the rates to be paid,~~ shall require the approval of the department PURSUANT TO SECTION 803 BEGINNING AT A TIME DETERMINED BY THE DEPARTMENT BUT NO LATER THAN TWO YEARS FROM THE ENACTMENT OF THE ACT. <--

~~For contracts between hospital providers and any hospital plan corporation, as defined in the act of December 15, 1972 (P.L.1062, No.274), requiring the approval of the Insurance Commissioner, the secretary shall approve the rates to be charged in the contract and the terms and conditions of rate payment and the Insurance Commissioner shall approve all other provisions not related to rates.~~ <--

~~(b) Nursing Home Rates.--Beginning January 1, 1977, all rates to be paid to nursing homes shall require the approval of the department.~~

~~(c) Other Rates.--Beginning January 1, 1978, all other rates~~ (B) ALL OTHER RATES to be paid to ~~health care~~ providers ~~not already subject to review~~ shall require the approval of the department PURSUANT TO SECTION 804 BEGINNING AT A TIME DETERMINED BY THE DEPARTMENT BUT NO LATER THAN TWO YEARS FROM THE ENACTMENT OF THE ACT. <--

~~(d) Discretionary Implementation.--Implementation of rate approval for hospital providers and skilled or intermediate care nursing facilities shall conform to the schedule prescribed by this section. Implementation of rate approval for all other classes of health care facilities shall be at such times and according to such schedules as the board determines, but in no~~ <--

~~event shall implementation precede the schedule prescribed for hospital providers.~~

~~Section 706. Standards.--(a) Rates, in the aggregate, when combined with available income from other sources, shall be reasonably related to the provider's total financial requirement (as defined by the board) necessary for the efficient production of services.~~

~~Such rates for for-profit health care providers shall allow a fair rate of return on the fair value of the investment.~~

~~Rates for nongovernmental health care providers shall incorporate incentives for increasing efficiency and/or improving services.~~

~~(b) In approving rates to be paid to health care providers, the department shall take into consideration the elements of allowable cost established by the Policy Board, the provider's total financial requirement, geographical differentials in the elements of cost considered, economic factors in the areas in which the provider is located, patient mix, and costs of providers of comparable size and services.~~

~~(c) The Policy Board shall take into consideration the principles of accounting established by the American Institute of Public Accountants, the chart of accounts established by the American Hospital Association, and any other appropriate standards utilized by health care providers.~~

SECTION 803. THIRD PARTY CONTRACT PAYOR.--(A) A THIRD PARTY <--
PAYOR SHALL BE DENOMINATED A THIRD PARTY CONTRACT PAYOR TO BE
REGULATED UNDER THIS SECTION IF IT SHALL AS A MATTER OF GENERAL
PRACTICE:

(1) NEGOTIATE AND ENTER INTO CONTRACTS WITH HOSPITAL
PROVIDERS FOR THE RENDITION OF HEALTH CARE SERVICES;

(2) ENTER INTO COST CONTROL ARRANGEMENTS WITH HOSPITAL
PROVIDERS;

(3) PROVIDE FOR REASONABLE OPEN ENROLLMENT PERIODS ON AN
ANNUAL OR SEMI-ANNUAL BASIS, WHEREBY INDIVIDUALS ARE ACCEPTED
FOR COMPREHENSIVE HEALTH CARE EXPENSE COVERAGE AND SERVICE
BENEFITS WITHOUT REGARD TO HEALTH;

(4) PROVIDE CONVERSION PRIVILEGES ON ALL GROUP CONTRACTS,
WHEREBY INDIVIDUALS NO LONGER ELIGIBLE FOR GROUP COVERAGE MAY
OBTAIN INDIVIDUAL COMPREHENSIVE HEALTH CARE EXPENSE COVERAGE AND
SERVICE BENEFITS WITHOUT REGARD TO HEALTH;

(5) PROVIDE FOR COVERAGE BY WAY OF SERVICE BENEFITS RATHER
THAN FIXED DOLLAR AMOUNT BENEFITS, IN ORDER TO PROVIDE
COMPREHENSIVE PROTECTION WHICH RESPONDS TO CHANGING MEDICAL
PROCEDURES AND TECHNOLOGY;

(6) PROVIDE GROUP COVERAGE WITH SERVICE BENEFITS FOR GROUPS
AS SMALL AS FIVE INDIVIDUALS;

(7) PROVIDE HEALTH CARE SERVICE BENEFITS ON A NON-GROUP
BASIS AT A REASONABLE EXPENSE RATIO;

(8) PROVIDE FOR CONSUMER PARTICIPATION THROUGH THE THIRD
PARTY CONTRACT PAYOR'S GOVERNING BOARD; AND

(9) ELIMINATE ANY CONTRACT OR COVERAGE WHICH PROVIDES
BENEFITS SO LIMITED AS TO BE OF NO SUBSTANTIAL ECONOMIC VALUE TO
THE POLICYHOLDER OR SUBSCRIBER, OR PROVIDES BENEFITS THAT ARE
UNREASONABLE IN RELATION TO THE PREMIUM CHARGED.

(B) THE INSURANCE COMMISSIONER SHALL CERTIFY ANNUALLY TO THE
SECRETARY THE FINDINGS OF THE INSURANCE DEPARTMENT WITHIN ITS
PURVIEW REGARDING COMPLIANCE WITH THE REQUIREMENTS FOR
ELIGIBILITY OF THIRD PARTY CONTRACT PAYORS.

(C) CONTRACTS BETWEEN PROVIDERS AND THIRD PARTY CONTRACT
PAYORS FOR THE PROVISION OF HEALTH CARE SERVICES, INCLUDING THE

RATES TO BE PAID, SHALL REQUIRE THE APPROVAL OF THE DEPARTMENT. FOLLOWING NEGOTIATIONS WITH HOSPITAL PROVIDERS TO BE AFFECTED THEREBY, CONDUCTED IN ACCORDANCE WITH STANDARDS ESTABLISHED BY THE DEPARTMENT, A THIRD PARTY CONTRACT PAYOR SHALL FILE WITH THE DEPARTMENT AN APPLICATION FOR APPROVAL OF ANY PROPOSED CONTRACT OR ANY MODIFICATIONS TO AN EXISTING CONTRACT. THE APPLICATION SHALL DESIGNATE THE PROVIDERS TO BE AFFECTED, BY NAME OR BY GEOGRAPHICAL DESIGNATION. THE DEPARTMENT SHALL PUBLISH NOTICE OF THE FILING OF THE APPLICATION AND SHALL SET A HEARING FOR A TIME NOT MORE THAN 30 DAYS FROM DATE OF PUBLICATION. A THIRD PARTY CONTRACT PAYOR SHALL HAVE THE RIGHT TO A HEARING CONDUCTED IN ACCORDANCE WITH THE PROVISIONS OF THE ACT OF JUNE 4, 1945 (P.L.1388, NO.442), KNOWN AS THE "ADMINISTRATIVE AGENCY LAW." WITHIN 60 DAYS AFTER RECEIPT OF THE FINDINGS AND CONCLUSIONS OF THE HEARING OFFICER, THE DEPARTMENT SHALL ISSUE AN ORDER APPROVING, DENYING OR APPROVING IN PART THE APPLICATION. IF THE DEPARTMENT TAKES NO ACTION WITHIN 60 DAYS AFTER SUCH RECEIPT, THE APPLICATION SHALL BE DEEMED APPROVED. ORDERS OF THE DEPARTMENT UPON AN APPLICATION FOR APPROVAL SHALL BE SUBJECT TO JUDICIAL REVIEW PURSUANT TO SECTION 405. UPON APPROVAL, ALL PROVIDERS DESIGNATED IN THE FILING OF THE APPLICATION SHALL BE BOUND BY THE TERMS THEREOF AS APPROVED BY THE DEPARTMENT. CONTRACT RATES SHALL, WITHIN THE TERMS ESTABLISHED BY THE CONTRACT, REQUIRE THE ANNUAL APPROVAL OF THE DEPARTMENT.

PROVISIONS IN TITLE 40 PA.C.S. § 6101, WHICH REQUIRE CONTRACTS BETWEEN A HOSPITAL PROVIDER AND ANY HOSPITAL PLAN CORPORATION TO BE APPROVED BY THE INSURANCE COMMISSIONER, ARE HEREBY REPEALED TO THE EXTENT OF THEIR INCONSISTENCY WITH THIS ACT. THE DEPARTMENT SHALL CERTIFY TO THE INSURANCE COMMISSIONER THE CONTRACTS AND CONTRACT RATES IT HAS APPROVED AND THE

INSURANCE COMMISSIONER SHALL ACCEPT SUCH CONTRACTS AND CONTRACT RATES IN CONNECTION WITH ANY PROCEEDINGS BEFORE THE INSURANCE COMMISSIONER RELATING TO RATES TO BE CHARGED TO, OR OTHER CONTRACT PROVISIONS WITH, SUBSCRIBERS OF THE HOSPITAL PLAN CORPORATION.

(D) RATES CONTAINED IN CONTRACTS SHALL BE REASONABLY RELATED TO THE COSTS (AS DEFINED BY THE DEPARTMENT) PROJECTED OR INCURRED BY PROVIDERS FOR THE EFFICIENT PRODUCTION OF SERVICES. THE DEPARTMENT SHALL TAKE INTO CONSIDERATION THE ELEMENTS OF ALLOWABLE COST, THE NEED FOR INCENTIVES TO IMPROVE SERVICES AND INSTITUTE ECONOMIES, GEOGRAPHICAL DIFFERENTIALS IN THE ELEMENTS OF COST CONSIDERED, ECONOMIC FACTORS IN THE AREAS IN WHICH THE PROVIDER IS LOCATED, PATIENT MIX, AND COSTS OF PROVIDERS OF COMPARABLE SIZE AND SERVICES. THE DEPARTMENT SHALL ALSO TAKE INTO CONSIDERATION THE ECONOMIES AND IMPROVEMENTS IN SERVICE TO BE ANTICIPATED FROM THE OPERATION OF JOINT CENTRAL SERVICES OR USE OF FACILITIES OR SERVICES WHICH MAY SERVE AS ALTERNATIVES OR SUBSTITUTES FOR THE WHOLE OR ANY PART OF ANY SERVICES, INCLUDING, BUT NOT LIMITED TO, OBSTETRICAL, PEDIATRIC, LABORATORY, RADIOLOGY, PHARMACY, LAUNDRY, PURCHASING, PRE-ADMISSION, NURSING HOME, AMBULATORY OR HOME CARE SERVICES. A THIRD PARTY CONTRACT PAYOR MAY EXCLUDE THOSE COSTS FOR RESEARCH AND EDUCATION DETERMINED TO BE NOT DIRECTLY RELATED TO PATIENT CARE AND COSTS OF PROVIDING HEALTH CARE SERVICES TO THOSE NOT RECEIVING BENEFITS THROUGH A THIRD PARTY CONTRACT PAYOR.

(E) IN ORDER TO NEGOTIATE AND ENTER INTO CONTRACTS WITH HEALTH CARE PROVIDERS, A THIRD PARTY CONTRACT PAYOR MAY CONDUCT INSPECTIONS, INVESTIGATIONS, AUDITS OR OTHER REVIEWS OF FINANCIAL AND OPERATIONAL REPORTS ON MATTERS RELATING TO HEALTH CARE FACILITIES AND SERVICES OF PROVIDERS.

SECTION 804. OTHER RATES.--(A) RATES PAID TO PROVIDERS WHICH ARE NOT APPROVED PURSUANT TO SECTION 802 SHALL REQUIRE THE APPROVAL OF THE DEPARTMENT.

(B) RATES, IN THE AGGREGATE, WHEN COMBINED WITH AVAILABLE INCOME FROM FEDERAL REIMBURSEMENTS, SHALL BE REASONABLY RELATED TO THE PROVIDER'S REASONABLE FINANCIAL NEEDS, AS DEFINED BY THE DEPARTMENT, NECESSARY FOR THE EFFICIENT PRODUCTION OF SERVICES. THE DEPARTMENT SHALL TAKE INTO CONSIDERATION THE ELEMENTS OF ALLOWABLE COST, THE NEED FOR INCENTIVES TO IMPROVE SERVICES AND INSTITUTE ECONOMIES, GEOGRAPHICAL DIFFERENTIALS IN THE ELEMENTS OF COST CONSIDERED, ECONOMIC FACTORS IN THE AREAS IN WHICH THE PROVIDER IS LOCATED, PATIENT MIX, AND COSTS OF PROVIDERS OF COMPARABLE SIZE AND SERVICES. THE DEPARTMENT SHALL ALSO TAKE INTO CONSIDERATION THE ECONOMIES AND IMPROVEMENTS IN SERVICE TO BE ANTICIPATED FROM THE CONSOLIDATION OF SERVICES OR USE OF ALTERNATIVES OR SUBSTITUTE SERVICES. RATES FOR FOR-PROFIT HOSPITAL PROVIDERS SHALL ALLOW A FAIR RATE OF RETURN ON THE FAIR VALUE OF THE INVESTMENT.

RATES FOR NONGOVERNMENTAL HEALTH CARE PROVIDERS SHALL INCORPORATE INCENTIVES FOR INCREASING EFFICIENCY AND/OR IMPROVING SERVICES.

(C) IN ORDER TO FACILITATE RATE APPROVAL, THE DEPARTMENT MAY ESTABLISH PERMISSIBLE MAXIMUM CHANGES IN RATES FOR PROVIDERS. IF THE RATES, AS FILED, FALL WITHIN THE MAXIMUM, THE RATE SHALL BE DEEMED TO BE APPROVED.

(d) The department may promote and approve alternative methods of rate determination or payment of an experimental or innovative nature.

Section ~~307~~ 805. Procedures.--(a) The ~~Policy Board~~ DEPARTMENT shall by rule, after consultation and public <--

hearings, establish procedures for the filing, review and determination of rates in a fair and expeditious manner AND FOR PROPER COORDINATION WITH THE APPROVAL OF CONTRACT RATES. <--

(B) RATES PAID BY THE COMMONWEALTH AS PAYMENTS TO PROVIDERS PURSUANT TO TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT AND RATES PAID TO A PROVIDER PURSUANT TO ANY AGREEMENT FOR THE PURCHASE OF SERVICES ON A GROUP BASIS SHALL BE REVIEWED AND IN ACCORDANCE WITH PROCEDURES ESTABLISHED BY THE DEPARTMENT.

~~(b)~~ (C) The department may require such information, including the provider's proposed budget, to be submitted to the department in support of a provider's rates OR CONTRACT RATES as it deems necessary. If the department by rule limits the expenditure of funds from capital accounts, the proposed budget may be used to verify such limitation upon audit. <--

~~(c)~~ (D) The department shall review rates within a ~~reasonable~~ DEFINITE period of time~~, as defined by the Policy Board, after the deadline for submission.~~ PRESCRIBED BY DEPARTMENTAL REGULATION. Rates not acted upon by the department within the prescribed time ~~limit~~ PERIOD shall be deemed approved automatically. <--

Section ~~308~~ 806. Opportunity to Be Heard.--Prior to approval of any rate OR CONTRACT RATE by the department the provider and any person interested as a consumer or third party payor shall be entitled to an opportunity to be heard on the reasonableness of such rate. <--

Section ~~309~~ 807. Rate Exceptions; Procedures.--(a) Any provider or any person interested as a consumer or third party payor may request an exception from the rate OR CONTRACT RATE approved by the department for good cause shown by petition to the ~~board.~~ SECRETARY. <--

(b) The ~~board~~ SECRETARY may ~~provide for~~ DIRECT the taking of evidence upon the petition~~, either~~ by appointment of an impartial hearing examiner. ~~or by designation of a board member or panel of members, by the chairman.~~ Such examiner~~, member or members~~ shall be authorized to administer oaths, compel the attendance of witnesses and the production of records or other information, and examine witnesses. Other parties interested as providers, consumers or third party payors may also present evidence and participate in the hearing. After the hearing, findings of fact, conclusions and recommendations shall be presented to the ~~board.~~ SECRETRAY.

(c) Within 60 days of the petition for an exception, unless extended by the ~~board~~ SECRETARY with the consent of the provider for no more than 60 additional days, the ~~board~~ SECRETARY shall either deny the petition or grant the petition in whole or in part and approve a new rate.

(d) Judicial appeals may be taken pursuant to section 405. ~~of this act.~~

SECTION 808. DEMONSTRATION FUNDS.--THE DEPARTMENT IS AUTHORIZED TO APPLY FOR DEMONSTRATION GRANTS FROM THE FEDERAL GOVERNMENT FOR IMPLEMENTATION OF RATE REVIEW SYSTEMS.

Section ~~710~~ 809. Public Inspection.--A ~~health care~~ provider's schedule of rates in force and a schedule of rates, if any, submitted to the department for its approval, with the required supporting information, shall be available for inspection by the public during business hours in the offices of the department, the provider and any contracting party.

Section ~~711~~ 810. Compliance.--No ~~health care~~ provider shall charge for services at rates other than those approved by the department. NO THIRD PARTY PAYOR SHALL MAKE PAYMENTS TO A

PROVIDER AT TERMS OTHER THAN THOSE APPROVED BY THE DEPARTMENT.

When a provider charges a rate higher than that approved by the department, the department may order compensatory adjustments in rates for subsequent years.

Section ~~712~~ 811. Penalty.--Any ~~health care~~ provider or officer, director or agent thereof who knowingly fails to comply with the requirements of this article shall, upon conviction thereof in a summary proceeding, be sentenced to pay a fine of not more than $300 and costs of prosecution, and/or to undergo imprisonment for not less than ~~40~~ TEN days and not more than 30 days: Provided, however, That the department may accept a civil forfeiture in settlement of an action. Each day of noncompliance shall constitute a separate offense.

SECTION 812. NOTHING IN THIS ARTICLE SHALL ABROGATE, ALTER, AFFECT OR DELAY THE IMPLEMENTATION OF A COLLECTIVE BARGAINING AGREEMENT.

ARTICLE ~~VII~~ IX

Proceedings Against Unlicensed Health Care Providers and Violators

Section ~~801~~ 901. Actions Against Unlicensed Health Care Providers.--Whenever a license is required by this act for the establishment, operating or conduct of a health care facility, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting any person from establishing, conducting or operating any unlicensed health care facility.

Section ~~802~~ 902. Actions Against Violations of Law and Rules and Regulations.--(A) Whenever any person, regardless of whether such person is a licensee, has violated any of the provisions of this act ~~pertaining to licensure~~ or the regulations issued

pursuant thereto, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting such person from engaging in such activity.

(B) ANY PERSON, REGARDLESS OF WHETHER SUCH PERSON IS A LICENSEE, WHO HAS COMMITTED A VIOLATION OF ANY OF THE PROVISIONS OF THIS ACT OR OF RULES AND REGULATIONS ISSUED PURSUANT THERETO SHALL UPON CONVICTION THEREOF IN A SUMMARY PROCEEDING BE SENTENCED TO PAY A FINE OF NOT MORE THAN $300, AND COSTS OF PROSECUTION AND/OR TO UNDERGO IMPRISONMENT FOR NOT MORE THAN TEN DAYS: PROVIDED, HOWEVER, THAT THE DEPARTMENT MAY ACCEPT A CIVIL FORFEITURE IN SETTLEMENT OF AN ACTION. EACH DAY THE VIOLATION CONTINUES SHALL CONSTITUTE A SEPARATE OFFENSE. <--

Section ~~803~~ 903. Injunction or Restraining Order When Appeal is Pending.--Whenever the department shall have refused to grant or renew a license, or shall have suspended or revoked a license required by this act to operate or conduct a health care facility, or shall have ordered the person to refrain from conduct violating the rules and regulations of the department and the person deeming himself aggrieved by such refusal or suspension or revocation or order shall have appealed from the action of the department, the Commonwealth Court may, during pendency of such appeal, issue a restraining order or injunction upon a showing that the continued operation of the health care facility adversely affects the well-being ~~and safety~~, SAFETY OR INTERESTS of the patients of the health care facility, or the court may authorize continued operation of the facility or make such other order pending final disposition of the case as justice and equity require. <--

Section ~~804~~ 904. Injunction or Restraining Order When No <--

Appeal is Pending.--Should a person, who is refused a license or the renewal of a license to operate or conduct a health care facility, or whose license to operate or conduct a health care facility is suspended or revoked, fail to appeal or should such appeal be decided finally favorably to the department, then the court shall issue a permanent injunction upon proof that the person is operating or conducting a health care facility without a license as required by this act.

Section ~~805~~ 905. Bonds and Costs.--No bond shall be required of the department in any legal action. <--

Section ~~806~~ 906. Remedies Supplementary.--The provisions of this article are supplementary to any other legal rights created in this act or any other act available for the enforcement of provisions of this act and rules and regulations promulgated thereunder. <--

ARTICLE ~~XI~~ X <--

General Provisions

Section ~~901~~ 1001. Licenses and Certificates for Existing Facilities.--All health care providers licensed or approved on the effective date of this act to conduct, maintain or operate a health care facility or who are operating such facility which has been licensed or approved, shall be issued a license immediately upon application and all such providers WHO ARE SUBJECT TO THE CERTIFICATE OF NEED PROVISIONS OF THE ACT shall be issued forthwith a certificate of need by the department for all buildings, real property and equipment owned, leased or being operated or under contract for construction, purchase or lease and for all services being rendered by the licensed or approved providers on the effective date of this act. To facilitate administration of this act, the department may <--

initially grant some licenses ~~and certificates of need~~ for <--
periods less than the prescribed term and may permit the running
of licenses or approvals currently granted to providers, as may
be required to stagger the dates for renewal.

Section ~~903~~ 1002. Administration of the Act.--(a) No health <--
care provider shall be required by any provisions of this act or
rules and regulations promulgated thereunder to provide
facilities or render services contrary to the stated religious
or moral beliefs of the provider, nor shall any applicant be
denied a license or a certificate of need or the right to apply
for or receive public funds on the grounds he will not provide
the facilities or render the services for such reasons.

(b) Except as otherwise provided by law, no provider shall
discriminate in the operation of a health care facility on the
basis of race, creed, sex or national origin.

(c) Consumers shall have freedom of choice in the selection
of health care facilities and nothing in this act or any rules
and regulations promulgated pursuant thereto shall be
interpreted to require any consumer to use any particular health
care facility or to be denied the use of any particular health
care facility; but such freedom shall not carry with it the
right to be attended therein by the consumer's personal
physician if the physician is not authorized to practice
therein.

(d) In carrying out the provisions of this act and other
statutes of this Commonwealth relating to health care
facilities, the department and ~~the~~ OTHER departments and ~~other~~ <--
agencies ~~and officials~~ of State and local governments shall make <--
every reasonable effort to prevent duplication of inspections
and examinations.

(e) The department shall not administer this act in a way
that will stifle innovation or experimentation in health care
and health care facilities or that will discourage contributions
of private funds and services to health care facilities.

Section ~~903~~ 1003. Appropriation.--The sum of $1,500,000, or <--
as much thereof as may be necessary, is hereby appropriated to
the department for the purpose of the administration and
enforcement of this act.

~~Section 904. Transfer of Powers.--The Advisory Health Board~~ <--
~~is abolished and its powers, duties and functions are hereby~~
~~transferred to the Health Care Policy Board.~~

~~Section 905~~ SECTION 1004. Repeals.--(a) The provisions of <--
Articles IX and X, act of June 13, 1967 (P.L.31, No.21), known
as the "Public Welfare Code" are repealed in so far as they
relate to health care facilities. HOWEVER, ON THE EFFECTIVE DATE <--
OF THE ACT ANY RULES OR REGULATIONS ISSUED UNDER THESE
PROVISIONS WILL REMAIN IN EFFECT UNTIL SUPERSEDED BY ORDER OF
THE DEPARTMENT.

(B) TO THE EXTENT THAT ANY PROVISIONS OF THE ACT IS IN
CONFLICT WITH THE PROVISIONS OF THE ACT OF DECEMBER 29, 1972
(P.L.1701, NO.364), KNOWN AS THE "VOLUNTARY NONPROFIT HEALTH
SERVICE ACT OF 1972," THE PROVISIONS OF THE LATTER ACT SHALL BE
CONTROLLING.

~~(b)~~ (C) All acts and parts of acts are hereby repealed in so <--
far as inconsistent with the provisions of this act.

Section ~~906~~ 1005. Effective Date.--This act shall take <--
effect ~~immediately~~ IN 90 DAYS. <--

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 427 Session of 1971

INTRODUCED BY OESTERLING, MESSINGER, CIANFRANI, AMMERMAN, MELLOW, MAZZEI, STAPLETON AND REIBMAN, MARCH 29, 1971

REFERRED TO PUBLIC HEALTH AND WELFARE, MARCH 29, 1971

AN ACT

Creating the Pennsylvania Hospital Control Commission as an independent administrative commission; defining the powers and duties of such commission; regulating the various rates charged by all hospitals within the Commonwealth; controlling the construction and utilization of such hospitals; regulating the premium rates for hospitalization insurance within the Commonwealth; providing procedures for the enforcement of the provisions of the act and providing penalties.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Hospital Control Commission Act."

Section 2. Legislative Findings.--Rising hospital costs are a matter of vital concern to the people of this State. The relentless increases in such costs encountered in recent years pose dangers to all purchasers of hospital services as well as hospitals themselves. The cost of hospital care is increasing faster than any other item in the consumer price index. The individual consumer has been spending a larger share of his earnings on hospital care and the average cost per hospital stay

continues to rise disproportionately to the increase in per capita income.

In part, hospital cost increases result from necessary improvement in wages and fringe benefits for hospital workers, improvements in equipment and service, and enhanced capability to save lives. However, while improved quality of services, increased use of facilities and rising prices are factors in accelerating hospital costs, there are nevertheless wide unexplained variations in the cost of the same services rendered by hospitals in the same area. Continued pressure for unnecessary duplication of facilities and heavy standby commitments for under-utilized services in one area contrast with long waiting lists for admission to facilities in other areas. Inefficient management and resultant higher costs need to be eliminated lest they threaten access to care and emergency services for many of our citizens.

The Legislature therefore finds and declares that it is essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs. It is the intent of this act to provide for uniform measures on a Statewide basis to control hospital costs without the sacrifice of quality of service.

Section 3. Definitions.--As used in this act--

"Commission" means the Pennsylvania Hospital Control Commission.

"Hospital" means any premises, other than a mental health establishment operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or

treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

Section 4. Pennsylvania Hospital Control Commission.--(a) An independent administrative commission to be known as the "Pennsylvania Hospital Control Commission" is hereby created. The commission shall consist of three members to be appointed by the Governor by and with the advice and consent of two-thirds of all members of the Senate. Of the original members, one shall be appointed for a term of two years, one for a term of four years, and one for a term of six years from the date of his appointment and until his successor shall have been appointed and qualified. Thereafter, all appointments shall be for terms of six years or until successors are appointed and qualified.

(b) Each member of the commission at the time of his appointment and qualification shall be a citizen of the United States and a resident of the Commonwealth of Pennsylvania and shall have been a qualified elector in the Commonwealth for a period of at least one year next preceding his appointment. No member of the commission during his period of service as such shall hold any other office under the laws of this Commonwealth or of the United States.

(c) The commission shall elect one of its members as chairman. The chairman shall, when present, preside at all meetings, and in his absence a member designated by the chairman shall preside. Two members of the commission shall constitute a quorum, and any action or order of the commission shall require

the approval of at least two members.

(d) The commission may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the commission by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the commission shall prescribe and shall receive such compensation as the commission shall determine.

(e) Annual salaries of the members of the commission shall be payable in equal installments every other week, as follows:

To the chairman of the commission..... $19,000

To the members of the commission..... 18,000

(f) Except as otherwise expressly provided by law, the commission shall be subject to all the provisions of the act of April 9, 1929 (P. L. 177), known as "The Administrative Code of 1929," as amended, which apply generally to independent administrative boards and commissions.

Section 5. Duties of Hospitals; Operating Certificates.--(a) It shall be the duty of every hospital within the Commonwealth, as herein defined:

(1) To submit to the commission for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospital;

(2) To submit to the commission for approval any plans for new construction or expansion of existing facilities at any such hospital;

(3) To submit to the commission for approval a plan for the utilization of all facilities at any such hospital.

(b) Every hospital within the Commonwealth, as herein defined, shall be subject to the provisions of this act and must

obtain from the commission an operating certificate, the possession of which shall be necessary for the rendering of any service by any such hospital.

Section 6. Duties of Certain Insurance Companies.--(a) Any insurance company which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth which issues policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the commission a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the commission.

Section 7. Powers and Duties of the Commission.--The commission shall have the power and its duty shall be:

(1) To grant operating licenses to hospitals which comply with the provisions of this act;

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by each hospital;

(3) To approve the plans for new construction or expansion of existing facilities at any hospital;

(4) To approve the plans for the utilization of facilities

at any hospital;

(5) To approve the classification of risks and premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth; and

(6) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration of the provisions of this act.

Section 8. Procedure Before the Commission.--(a) The commission may on its own motion or shall upon the petition of any hospital or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the commission has the power and duty to grant its approval.

(b) All hearings before the commission shall be public, and shall be conducted in accordance with such regulations as the commission may prescribe. A full and complete record shall be kept of all proceedings had before the commission on any formal hearing, and all testimony shall be taken down by a reporter appointed by the commission, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The commission shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The

fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The commission may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital or insurance company subject to this act. In conducting such investigations the commission may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the commission shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the commission, shall be served by registered mail upon the hospital or insurance company against whom it runs, or its attorney, and notice thereof shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become operative as designated therein, and shall continue in force either for a period which may be designated therein, or until changed or revoked by the commission. If an order cannot, in the judgment of the commission, be complied with within the time designated therein, the commission may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The commission may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it.

Any order rescinding or amending a prior order shall, when served upon the hospital or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

Section 9. Appeals to Courts.--(a) Within thirty days after the service of any order by the commission, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the commission, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant verily believes that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Section 10. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital or insurance company, who or which shall knowingly fail, omit, neglect or

refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the commission, or any order of the commission prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the costs of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the discretion of the court.

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 600 Session of 1971

INTRODUCED BY MESSRS. GELFAND, SCHMITT, BRUNNER, RAPPAPORT AND GREENFIELD, MARCH 30, 1971

REFERRED TO COMMITTEE ON CONSUMER PROTECTION, MARCH 30, 1971

AN ACT

Creating the Pennsylvania Health Agency as an independent administrative agency; defining the powers and duties of such agency; regulating the delivery, furnishing, planning, providing and sale of all health and medical services and products within the Commonwealth and regulating the construction and purchase of capital facilities used therein; providing procedures for the enforcement of the provisions of the act; making an appropriation and providing penalties.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Health Agency Act."

Section 2. Definitions.--As used in this act--

(1) "Agency" means the Pennsylvania Health Agency.

(2) "Control board" means one of the five designated boards of the agency.

(3) "Hospital" means any premises, other than a mental health establishment, operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or

treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

(4) "Health care facilities" means any premises not included or specifically excluded in the definition of "hospital" and used in the performance of health care or services except the office of an individual practicing physician shall not be included.

(5) "Health care personnel" means all persons, whether professional or nonprofessional, involved in any manner in rendering health care or services.

Section 3. Pennsylvania Health Agency.--(a) An independent administrative agency to be known as the "Pennsylvania Health Agency" is hereby created. The agency shall be divided into five control boards, as follows:

(1) The Hospital Control Board;

(2) The Health Services Control Board;

(3) The Health Profession Control Board;

(4) The Health Facilities Control Board; and

(5) The Health Planning Board.

(b) The agency shall consist of fifteen members, three of whom shall also serve as members of the Hospital Control Board, three of whom shall also serve on the Health Services Board, three of whom shall also serve on the Health Profession Control Board, three of whom shall also serve on the Health Facilities Control Board, and three of whom shall serve on the Health Planning Board. Each member shall be appointed by the Governor,

by and with the advice and consent of two-thirds of all the members of the Senate, and shall, except as hereinafter provided, hold office for terms of four years each and until his successor has been appointed and qualified.

(c) Of the members first appointed, four shall be appointed for a term of one year, four shall be appointed for a term of two years, four shall be appointed for a term of three years and three shall be appointed for a term of four years. Thereafter, all terms shall be for four years, except that an appointment to fill a vacancy shall be for the unexpired term.

(d) Eight members shall constitute a quorum provided that at least one member from each of the control boards is present. The affirmative vote of a majority of all the members of the agency duly recorded showing how each member voted shall be required in order to take action adopting policies, standards, rules and regulations. The agency shall meet at least twice monthly. Special meetings may be called by the chairman or at the request of a majority of the members of the agency.

(e) The agency shall elect one of its members as chairman and each of the control boards shall also elect one of its members as chairman. The chairman of the agency and of each of the control boards shall, when present, preside at all meetings of the agency or control board, as the case may be, and in his absence a member designated by such chairman shall preside.

(f) The agency may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the agency by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the agency shall prescribe and shall receive such

compensation as the agency shall determine.

(g) Annual salaries of the members of the agency shall be payable in equal installments every other week, as follows:

To the chairman of the agency..... $19,000

To the members of the agency..... 18,000

(h) Except as otherwise expressly provided by law, the agency shall be subject to all the provisions of the act of April 9, 1929 (P.L.177), known as "The Administrative Code of 1929," which apply generally to independent administrative boards and commissions.

Section 4. Powers and Duties of the Agency.--The agency shall have the power and its duty shall be:

(1) To develop a master plan for health services and health care within the Commonwealth to assure quality service and care to each resident at the least possible cost. Such master plan shall be known as "The Pennsylvania Health System."

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by any hospital or health care facility.

(3) To approve the utilization of facilities and equipment at any hospital or health care facility.

(4) To approve the educational and teaching programs conducted at any hospital or health care facility.

(5) To approve all systems of budgets, accounting and record keeping and reporting at any hospital or health care facility.

(6) To make investigations and audits of the operations and financial affairs of any hospital or health care facility.

(7) To approve the number of personnel employed by any hospital or health care facility and the compensation paid to

such personnel.

(8) To approve the plans for new construction or expansion of existing facilities at any hospital or health care facility; to formulate programs for funding such plans and to administer all such programs.

(9) To approve the classification of risks and the premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth.

(10) To approve the accounting, bookkeeping, billing and record keeping procedures of all health care personnel who bill insurance companies or some other third party for health care or services.

(11) To require financial and operational reports from hospitals, health care facilities and health care personnel and to perform audits and investigations relative to the enforcement thereof.

(12) To approve the curricula, standards for teachers and requirements for graduation or successful completion of any course of study or training given for health care personnel within the Commonwealth.

(13) To approve the number of health care personnel to be trained or taught at any skill level or profession within the Commonwealth.

(14) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration and enforcement of the provisions of this act.

All of the powers and duties herein imposed upon the agency shall also be applicable to each of the control boards of the

agency. The agency shall determine the areas of responsibility for each of the control boards.

Section 5. Duties of Hospitals, Health Care Facilities and Health Care Personnel.--It shall be the duty of all hospitals, health care facilities and health care personnel:

(1) To submit to the agency for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospitals or health care centers.

(2) To submit to the agency for approval any plans for new construction or expansion of existing facilities at any such hospital or health care center.

(3) To submit to the agency for approval a plan for the utilization of all facilities at any such hospital or health care center.

(4) To submit to the agency for approval all teaching and educational programs to be conducted at any such hospital or health care center.

(5) To file all reports required by the agency relating to the operational or financial status of any such hospital or health care center and to cooperate with agents of the agency investigating or conducting audits relating to such matter.

(6) To establish and use such systems of budgets, accounting, record keeping and reporting at any such hospital or health care center as the agency may require.

(7) To comply with all orders, rules and regulations of the agency relating to such hospitals, health care centers or health care personnel.

Section 6. Duties of Certain Insurance Companies.--(a) Any insurance company which is subject to the jurisdiction of the

Insurance Commissioner of the Commonwealth which issues policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the agency a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the agency.

Section 7. Procedure Before the Agency or Control Boards.--(a) The agency or any control board may on its own motion or shall upon the petition of any hospital, health care center, health care personnel or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the agency or control board has the power and duty to grant its approval.

(b) All hearings before the agency or any control board shall be public, and shall be conducted in accordance with such regulations as the agency or control board may prescribe. A full and complete record shall be kept of all proceedings had before the agency or control board on any formal hearing, and all testimony shall be taken down by a reporter appointed by the agency or control board, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The agency or control board shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The agency or control board may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital, health care center or health care personnel or insurance company subject to this act. In conducting such investigations the agency or control board may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the agency or control board shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the agency, shall be served by registered mail upon the hospital, health care center or health care personnel or insurance company against whom it runs, or its attorney, and notice thereof shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become operative as designated therein, and shall continue in

force either for a period which may be designated therein, or until changed or revoked by the agency or control board. If an order cannot, in the judgment of the agency or control board, be complied with within the time designated therein, the agency or control board may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The agency or control board may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it. Any order rescinding or amending a prior order shall, when served upon the hospital, health care center, health care personnel or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital, health care center, health care personnel or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

(g) Within thirty days after the service of any order by a control board, any party to the proceedings affected thereby may appeal therefrom to the entire membership of the agency.

Section 8. Appeals to Courts.--(a) Within thirty days after the service of any order by the agency, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case

shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the agency, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant believes that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Section 9. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital, health care center or insurance company, who or which shall knowingly fail, omit, neglect or refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the agency or control board, or any order of the agency or control board prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the cost of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the

discretion of the court.

Section 10. Appropriation.--The sum of one million dollars ($1,000,000), or as much thereof as may be necessary, is hereby specifically appropriated to the Pennsylvania Health Agency, for the fiscal year beginning July 1, 1971 and ending June 30, 1972, for the purpose of the administration and enforcement of the provisions of this act.

Section 11. Effective Date.--This act shall take effect immediately.

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2183 Session of 1970

INTRODUCED BY MESSRS. GELFAND, SCHMITT, ZEARFOSS, GALLAGHER, BERKES, PEZAK, SHERMAN, TAYLOR, HOPKINS, FRANK, BLAIR AND POLASKI, MARCH 17, 1970

REFERRED TO COMMITTEE ON CONSUMER PROTECTION, MARCH 17, 1970

AN ACT

Creating the Pennsylvania Health Agency as an independent administrative agency; defining the powers and duties of such agency; regulating the delivery, furnishing, planning, providing and sale of all health and medical services and products within the Commonwealth and regulating the construction and purchase of capital facilities used therein; providing procedures for the enforcement of the provisions of the act; making an appropriation and providing penalties.

THE GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA HEREBY ENACTS AS FOLLOWS:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Health Agency Act."

Section 2. Definitions.--As used in this act - -

(1) "Agency" means the Pennsylvania Health Agency.

(2) "Control board" means one of the five designated boards of the agency.

(3) "Hospital" means any premises, other than a mental health establishment, operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

(4) "Health care facilities" means any premises not included or specifically excluded in the definition of "hospital" and used in the performance of health care or services except the office of an individual practicing physician shall not be included.

(5) "Health care personnel" means all persons, whether professional or nonprofessional, involved in any manner in rendering health care or services.

Section 3. Pennsylvania Health Agency.--(a) An independent administrative agency to be known as the "Pennsylvania Health Agency" is hereby created. The agency shall be divided into five control boards as follows: (i) the Hospital Control Board; (ii) the Health Services Control Board; (iii) the Health Profession Control Board; (iv) the Health Facilities Control Board; and (v) the Health Planning Board.

(b) The agency shall consist of fifteen members, three of whom shall also serve as members of the Hospital Control Board, three of whom shall also serve on the Health Services Board, three of whom shall also serve on the Health Profession Control Board, three of whom shall also serve on the Health Facilities Control Board, and three of whom shall serve on the Health Planning Board. Each member shall be appointed by the Governor, by and with the advice and consent of two-thirds of all the members of the Senate, and shall, except as hereinafter provided, hold office for terms of four years each and until his successor has been appointed and qualified.

(c) Of the members first appointed, four shall be appointed for a term of one year, four shall be appointed for a term of two years, four shall be appointed for a term of three years and three shall be appointed for a term of four years. Thereafter, all terms shall be for four years, except that an appointment to fill a vacancy shall be for the unexpired term.

(d) Eight members shall constitute a quorum provided that at least one member from each of the control boards is present. The affirmative vote of a majority of all the members of the agency duly recorded showing how each member voted shall be required in order to take action adopting policies, standards, rules and regulations. The agency shall meet at least twice monthly. Special meetings may be called by the chairman or at the request of a majority of the members of the agency.

(e) The agency shall elect one of its members as chairman and each of the

control boards shall also elect one of its members as chairman. The chairman of the agency and of each of the control boards shall, when present, preside at all meetings of the agency or control board, as the case may be, and in his absence a member designated by such chairman shall preside.

(f) The agency may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the agency by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the agency shall prescribe and shall receive such compensation as the agency shall determine.

(g) Annual salaries of the members of the agency shall be payable in equal installments every other week, as follows:

To the chairman of the agency..... $19,000

To the members of the agency 18,000

(h) Except as otherwise expressly provided by law, the agency shall be subject to all the provisions of the act of April 9, 1929 (P. L. 177), known as "The Administrative Code of 1929," as amended, which apply generally to independent administrative boards and commissions.

Section 4. Powers and Duties of the Agency.--The agency shall have the power and its duty shall be:

(1) To develop a master plan for health services and health care within the Commonwealth to assure quality service and care to each resident at the least possible cost. Such master plan shall be known as "The Pennsylvania Health System."

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by any hospital or health care facility.

(3) To approve the utilization of facilities and equipment at any hospital or health care facility.

(4) To approve the educational and teaching programs conducted at any hospital or health care facility.

(5) To approve all systems of budgets, accounting and record keeping and

reporting at any hospital or health care facility.

(6) To make investigations and audits of the operations and financial affairs of any hospital or health care facility.

(7) To approve the number of personnel employed by any hospital or health care facility and the compensation paid to such personnel.

(8) To approve the plans for new construction or expansion of existing facilities at any hospital or health care facility; to formulate programs for funding such plans and to administer all such programs.

(9) To approve the classification of risks and the premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth.

(10) To approve the accounting, bookkeeping, billing and record keeping procedures of all health care personnel who bill insurance companies or some other third party for health care or services.

(11) To require financial and operational reports from hospitals, health care facilities and health care personnel and to perform audits and investigations relative to the enforcement thereof.

(12) To approve the curricula, standards for teachers and requirements for graduation or successful completion of any course of study or training given for health care personnel within the Commonwealth.

(13) To approve the number of health care personnel to be trained or taught at any skill level or profession within the Commonwealth.

(14) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration and enforcement of the provisions of this act.

All of the powers and duties herein imposed upon the agency shall also be applicable to each of the control boards of the agency. The agency shall determine the areas of responsibility for each of the control boards.

Section 5. Duties of Hospitals, Health Care Facilities and Health Care Personnel.--It shall be the duty of all hospitals, health care facilities and health care personnel, as herein defined:

(1) To submit to the agency for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospitals or health care centers.

(2) To submit to the agency for approval any plans for new construction or expansion of existing facilities at any such hospital or health care center.

(3) To submit to the agency for approval a plan for the utilization of all facilities at any such hospital or health care center.

(4) To submit to the agency for approval all teaching and educational programs to be conducted at any such hospital or health care center.

(5) To file all reports required by the agency relating to the operational or financial status of any such hospital or health care center and to cooperate with agents of the agency investigating or conducting audits relating to such matter.

(6) To establish and use such systems of budgets, accounting, record keeping and reporting at any such hospital or health care center as the agency may require.

(7) To comply with all orders, rules and regulations of the agency relating to such hospitals, health care centers or health care personnel.

Section 6. Duties of Certain Insurance Companies.--(a) Any insurance company which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth which issue policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the agency a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the agency.

Section 7. Procedure Before the Agency or Control Boards.--(a) The agency or any control board may on its own motion or shall upon the petition of any hospital,

health care center, health care personnel or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the agency or control board has the power and duty to grant its approval.

(b) All hearings before the agency or any control board shall be public, and shall be conducted in accordance with such regulations as the agency or control board may prescribe. A full and complete record shall be kept of all proceedings had before the agency or control board on any formal hearing, and all testimony shall be taken down by a reporter appointed by the agency or control board, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The agency or control board shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The agency or control board may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital, health care center or health care personnel or insurance company subject to this act. In conducting such investigations the agency or control board may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the agency or control board shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the agency, shall be served by registered mail upon the hospital, health care center or health care personnel or insurance company against whom it runs, or its attorney, and notice thereof shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become

operative as designated therein, and shall continue in force either for a period which may be designated therein, or until changed or revoked by the agency or control board. If an order cannot, in the judgment of the agency or control board, be complied with within the time designated therein, the agency or control board may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The agency or control board may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it. Any order rescinding or amending a prior order shall, when served upon the hospital, health care center, health care personnel or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital, health care center, health care personnel or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

(g) Within thirty days after the service of any order by a control board, any party to the proceedings affected thereby may appeal therefrom to the entire membership of the agency.

Section 8. Appeals to Courts.--(a) Within thirty days after the service of any order by the agency, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the agency, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant verily believes

that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Section 9. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital, health care center or insurance company, who or which shall knowingly fail, omit, neglect or refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the agency or control board, or any order of the agency or control board prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the costs of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the discretion of the court.

Section 10. Appropriation.--The sum of one million dollars ($1,000,000), or as much thereof as may be necessary, is hereby specifically appropriated to the Pennsylvania Health Agency, for the fiscal year beginning July 1, 1970 and ending June 30, 1971, for the purpose of the administration and enforcement of the provisions of this act.

Section 11. Effective Date.--This act shall take effect immediately.

SEP 15 1969 33

Printer's No. 1109

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 994 Session of 1969

INTRODUCED BY KLINE, OESTERLING, PECHAN, WOOD AND KALMAN, JULY 22, 1969

REFERRED TO PUBLIC HEALTH AND WELFARE, JULY 22, 1969

AN ACT

Creating the Pennsylvania Hospital Control Commission as an independent administrative commission; defining the powers and duties of such commission; regulating the various rates charged by all hospitals within the Commonwealth; controlling the construction and utilization of such hospitals; regulating the premium rates for hospitalization insurance within the Commonwealth; providing procedures for the enforcement of the provisions of the act and providing penalties.

THE GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA HEREBY ENACTS AS FOLLOWS:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Hospital Control Commission Act."

Section 2. Legislative Findings.--Rising hospital costs are a matter of vital concern to the people of this State. The relentless increases in such costs encountered in recent years pose dangers to all purchasers of hospital services as well as hospitals themselves. The cost of hospital care is increasing faster than any other item in the consumer price index. The individual consumer has been spending a larger share of his earnings on hospital care and the average cost per hospital stay continues to rise disproportionately to the increase in per capita income.

In part, hospital cost increases result from necessary improvement in wages and fringe benefits for hospital workers, improvements in equipment and service, and enhanced capability to save lives. However, while improved quality of services, increased use of facilities and rising prices are factors in accelerating hospital costs,

there are nevertheless wide unexplained variations in the cost of the same services rendered by hospitals in the same area. Continued pressure for unnecessary duplication of facilities and heavy standby commitments for under-utilized services in one area contrast with long waiting lists for admission to facilities in other areas. Inefficient management and resultant higher costs need to be eliminated lest they threaten access to care and emergency services for many of our citizens.

The Legislature therefore finds and declares that it is essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs. It is the intent of this act to provide for uniform measures on a Statewide basis to control hospital costs without the sacrifice of quality of service.

Section 3. Definitions.--As used in this act--

"Commission" means the Pennsylvania Hospital Control Commission.

"Hospital" means any premises, other than a mental health establishment operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

Section 4. Pennsylvania Hospital Control Commission.--(a) An independent administrative commission to be known as the "Pennsylvania Hospital Control Commission" is hereby created. The commission shall consist of three members to be appointed by the Governor by and with the advice and consent of two-thirds of all members of the Senate. Of the original members, one shall be appointed for a term of two years, one for a term of four years, and one for a term of six years from the date of his appointment and until his successor shall have been appointed and qualified. Thereafter, all appointments shall be for terms of six years or until successors are appointed and qualified.

(b) Each member of the commission at the time of his appointment and qualification shall be a citizen of the United States and a resident of the Commonwealth of

Pennsylvania and shall have been a qualified elector in the Commonwealth for a period of at least one year next preceding his appointment. No member of the commission during his period of service as such shall hold any other office under the laws of this Commonwealth or of the United States.

(c) The commission shall elect one of its members as chairman. The chairman shall, when present, preside at all meetings, and in his absence a member designated by the chairman shall preside. Two members of the commission shall constitute a quorum, and any action or order of the commission shall require the approval of at least two members.

(d) The commission may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the commission by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the commission shall prescribe and shall receive such compensation as the commission shall determine.

(e) Annual salaries of the members of the commission shall be payable in equal installments every other week, as follows:

To the chairman of the commission..... $19,000

To the members of the commission..... 18,000

(f) Except as otherwise expressly provided by law, the commission shall be subject to all the provisions of the act of April 9, 1929 (P. L. 177), known as "The Administrative Code of 1929," as amended, which apply generally to independent administrative boards and commissions.

Section 5. Duties of Hospitals; Operating Certificates.—(a) It shall be the duty of every hospital within the Commonwealth, as herein defined:

(1) To submit to the commission for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospital;

(2) To submit to the commission for approval any plans for new construction or expansion of existing facilities at any such hospital;

(3) To submit to the commission for approval a plan for the utilization of all facilities at any such hospital.

(b) Every hospital within the Commonwealth, as herein defined, shall be subject to the provisions of this act and must obtain from the commission an operating certificate, the possession of which shall be necessary for the rendering of any service by such hospital.

Section 6. Duties of Certain Insurance Companies.—Any insurance company which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth which issue policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the commission a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the commission.

Section 7. Powers and Duties of the Commission.—The commission shall have the power and its duty shall be:

(1) To grant operating licenses to hospitals which comply with the provisions of this act;

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by each hospital;

(3) To approve the plans for new construction or expansion of existing facilities at any hospital;

(4) To approve the plans for the utilization of facilities at any hospital;

(5) To approve the classification of risks and the premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth; and

(6) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration of the provisions of this act.

Section 8. Procedure Before the Commission.--(a) The commission may on its own motion or shall upon the petition of any hospital or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the commission has the power and duty to grant its approval.

(b) All hearings before the commission shall be public, and shall be conducted in accordance with such regulations as the commission may prescribe. A full and complete record shall be kept of all proceedings had before the commission on any formal hearing, and all testimony shall be taken down by a reporter appointed by the commission, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The commission shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The commission may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital or insurance company subject to this act. In conducting such investigations the commission may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the commission shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the commission, shall be served by registered mail upon the hospital or insurance company against whom it runs, or its attorney, and notice thereof

shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become operative as designated therein, and shall continue in force either for a period which may be designated therein, or until changed or revoked by the commission. If an order cannot, in the judgment of the commission, be complied with within the time designated therein, the commission may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The commission may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it. Any order rescinding or amending a prior order shall, when served upon the hospital or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

Section 9. Appeals to Courts.--(a) Within thirty days after the service of any order by the commission, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the commission, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant verily believes that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Exhibit 33E

Section 10. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital or insurance company, who or which shall knowingly fail, omit, neglect or refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the commission, or any order of the commission prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the costs of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the discretion of the court.

Exhibit 35

PRINCIPLES OF PAYMENT FOR HOSPITAL CARE

THE GROWTH OF PROGRAMS by which third-party agencies pay hospital bills for groups of beneficiaries has raised important questions as to the amounts which should be paid to hospitals for care. Individual patients require different services and individual hospitals establish different regular charges for nominally similar services.

The differences in patient needs and hospital charges require special agreements between hospitals and third-party agencies whenever the former agree to furnish specific services, and the latter agree to make payments for those services. The payments must be adequate in total and equitable among hospitals.

A third party's liability to a hospital may be merely the payment of a certain dollar amount (indemnity or cash benefit) toward the charges for services rendered. Such liability does not require a contractual arrangement between the hospitals and third-party agencies, except for such matters as extension of credit to patients or authority to make payments directly to the hospitals.

Any contract to provide service should protect a hospital's financial interest and its program of public service. Payments should encourage high standards, administrative efficiency, institutional freedom, and the rendering of service in the interest of patient welfare.

Two broad bases are available for developing a method of reimbursement of hospitals for service benefits, namely the *"charges" established* by the hospitals and the *"costs" incurred* by them.

The prevailing sociologic and economic factors and medico-hospital relationships in a given area determine the degree of success or failure of any method of payment

for hospital care. Because of the general public interest in hospital operations, any method of payment which enables a single agency to control the number of services rendered to patients and the charges established for such service is undesirable. Such control leads to interference in hospital management and can affect adversely the quality of care rendered to patients. Therefore, a system of payment which permits purchasers of large quantities of hospital care to gain control of hospital management is to be avoided.

Payment of existing charges, as established from time to time by each institution, requires no special contractual arrangement between the hospital and the third-party agency. Any patient or his financial sponsor is privileged to pay established charges if he has the money.

The two conferences sponsored by the American Hospital Association in 1951 and 1953, and attended by representatives of both hospitals and third-party agencies, made only passing reference to established charges as the basis of contract payment for services in hospitals. The conference reports expressed the view that reimbursement from third parties should not exceed the amounts charged to non-contract patients receiving similar care in the same hospitals.

Under the principle of free enterprise, individual full-pay patients would expect to pay approximately the same amounts for the same services in the same community. But in the long run, established charges to individual patients cannot be expected to control the amounts paid by large-scale contractors who guarantee definite payments for all their clients. The amount paid by such a contracting agency will tend to equal the cost of the services rendered to its clients.

A hospital or group of hospitals must, over a period of time, be reimbursed for the "full" cost of services

which they provide. Conversely, all responsible third-party contractors should be prepared to pay for the full costs of services furnished to their beneficiaries. Many problems must be solved in the application of this fundamental principle.

Individual hospitals face different financial problems. But they must deal with contracting agencies as a group. A contractual arrangement within a community must be guided by equity for the majority of hospitals which agree to provide service.

The following principles of payment are intended to outline standards of adequacy and equity for contract payments for services furnished by hospitals to beneficiaries of third-party agencies, such as Blue Cross Plans, governmental bodies and other organizations which engage in the purchase of hospital services on behalf of groups of individuals.

1.000 BASIS FOR PAYMENT

The amount and method of payment to hospitals should be such as (1) to pay fairly and adequately for services purchased, (2) to maintain essential services, and (3) to encourage the development of higher standards of service to meet the needs of the community. 1.100

COMMENT . . . *The financing of hospital care requires recognition of the need for expanding health services with their attendant requirements. The hospital administrator and the medical staff must have assurance that the amount and method of payment will be adequate to cover the current costs of pro-*

viding the services which are requisite to necessary care, and that payments can be adjusted from time to time to meet the cost of expanded and improved quality of care.

1.200 Agencies purchasing hospital services should pay the "full cost" incurred in providing services for which they are responsible under their agreements with hospitals.

COMMENT . . . *Hospital income from patients whose bills are the responsibility of a third party should equal the "full cost" incurred by the hospital in providing a high quality of care. The term "full cost" as used here assumes the acceptance of definitions of cost in the succeeding sections of this report. This principle also implies that both parties (agency and hospital) are agreed as to contract services that are to be provided and as to the method of computing the contract payments that are to be made.*

1.201 A hospital should apply uniform principles for determining rates of reimbursement for similar services for all third-party agencies.

COMMENT . . . *The formulas used for establishing contract payments by third-party agencies should be applied uniformly for all such organizations. The amount of contract payment necessarily will vary for different third-party agencies, if the agencies contract to pay for different types of service for their beneficiaries. The most important principle is that each third-party agency should contract to pay the "full cost" for whatever services are agreed upon.*

1.202 Third-party agencies should not be expected to pay for that portion of the cost of specific cases which has been or will be paid for from other revenues designated for such cases.

COMMENT . . . *A hospital should not receive income for the same service from two separate sources. A hospital however, should not be expected to furnish services below "full cost" to third-party agencies merely because it receives income for general purposes from some other source.*

1.300 Hospitals which are paid the "full cost" of services they render to beneficiaries of third-party purchasers must accept the obligation of making available essential facilities and a high quality of service, with due regard to economy and efficiency.

COMMENT . . . *Hospitals which are paid "full cost" must assume basic obligations to provide essential facilities and high quality service at minimal expense and maximal operational efficiency. The acceptance of this principle involves both self-imposed and externally applied judgments of adequacy, deficiency or extravagance of hospital administration.*

1.400 Established rates to self-paying patients for similar services and accommodations should be based upon and be reasonably related to the "full cost."

COMMENT . . . *Where established rates for self-paying patients are less than "full cost," it is difficult to justify contract payments from third-party agencies that are based on "full cost." Charity and other allowances should be granted on an individual basis and should not be a factor in rate setting. It is not practicable for the charge for every item of service to reflect its individual cost, but the composite regular charges for contract service should at least equal the composite costs of such care.*

1.500 Rates of payment should reflect current hospital costs.

COMMENT . . . *Rates of payment should be related directly to "full cost" in the period in which care is given, insofar as administratively possible. A procedure for retroactive adjustment to current costs should be mutually agreed upon. This principle is important in that hospital costs must be met in terms of current price and wage levels. It is, therefore, in the interest of the third-party agency and the hospital to devise a method by which costs may be computed and payments adjusted promptly to reflect current variations.*

1.600 Payments to different hospitals for the same service may differ.

COMMENT . . . *Hospitals differ in physical design, equipment, accessibility, location, legal responsibilities, community responsi-*

bilities, medical staff, percentage of utilization, and in many other details. For these reasons hospitals may provide comparable quality in specific patient services at varying unit costs.

One hospital frequently is unable to maintain as high a percentage of occupancy or as complete utilization of diagnostic facilities as another institution. This adversely affects costs. But even the resultant higher costs may be justified because of the need for standby service in the community.

2.000 DETERMINATION OF "FULL COST"

The determination of "full cost" principles of payment requires acceptance and use of uniform definitions, accounting, statistics, and reporting. 2.100

COMMENT . . . *Any systematic payment program requires an orderly procedure of reporting in order that the payment program may be administered fairly and expeditiously. Hospitals must agree to provide the basic information necessary for comparable analysis of cost and equitable distribution of payments by third-party purchasers. Reimbursement at "full cost" by third-party agencies is dependent upon their knowledge of the procedures used in providing the data. Only through uniformity of records and reports can third-party agencies be as-*

sured that they are paying for similar services in different hospitals on comparable bases.

2.200 The principles described in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals should be used in determining "full cost."

COMMENT . . . *Official standard definitions, accounting procedures, statistical procedures, and methods of reporting among hospitals are those described in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals. Their uniform use, nationally will contribute to better accounting by hospitals and better understanding of costs and cost factors by third-party purchasers.*

2.300 It is essential that the principle of reimbursement of hospitals at "full cost" be embodied in a reimbursable cost formula (such as, "The Hospital Statement of Reimbursable Cost, Joint Hospital Form #1"). This may be used to determine the total cost of operations for the purpose of computing a general average cost per inpatient day or other unit of service. Such an average cost figure should be used when applicable to the services which a hospital or hospitals agree to furnish. Under other circumstances the average may serve as a basis for adjustment, up or down, according

to the scope and content of an agreement with respect to cases covered, accommodations used, extent of services, or other major considerations.

Attention is called to the recommendations indicated in 2.301 to 2.311 with respect to certain items which are sufficiently important to justify special mention for inclusion or exclusion in the computation of "full cost."

COMMENT . . . *An average per diem cost, computed under a reimbursable cost formula, such as, the "Hospital Statement of Reimbursable Cost, Joint Hospital Form #1," should be used to establish a rate of payment under contractual agreements with third-party agencies when the patients for whom a contracting agency is responsible are average for the hospital concerned.*

Patients paid for by specific third-party agencies may be atypical for a variety of reasons. For example, all patients might be hospitalized for obstetrical care, and "full cost" for this group might not be average cost for all patients in the hospital. A third-party agency might wish to have all of its beneficiaries hospitalized in semi-private rooms which might cost more than average cost, or all beneficiaries of another agency might be chronic patients requiring long periods of hospitalization with relatively small amounts of special services at less than average cost. In such situations, it may be necessary to develop more detailed cost data

or other factual information for the purpose of demonstrating the extent to which a reimbursable rate should deviate from the overall average patient day cost.

2.301 Major expenditures identifiable as being made for medical research purposes, over and beyond the usual care of patients, should not be included in determining "full cost" of patient care and services.

COMMENT . . . *Research ultimately results in better patient care; its benefits usually are derived over long periods of time and are not always of direct benefit to patients in the hospital at the time the research is being conducted. It is therefore reasonable that such desirable pioneering efforts be financed from sources other than the patients being served in a particular hospital. Such other sources might be eleemosynary foundations, philanthropic contributors, and tax-supported agencies.*

Those paying for hospital care should understand that the quality of care in any hospital is improved by research and that any increased cost is reflected in better care because of the incentive provided for better service by those working in such a hospital.

2.302 In determining "full cost," a reasonable amount for medical, nursing and other education not reimbursed through tuition, scholarships, grants, or other community contributions is a legitimate inclusion in the

interest of continuing to upgrade quality of service to the community. The community should assist ultimately in the support of such educational programs.

COMMENT . . . *Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining "full cost" of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources.*

2.303 Income specifically designated for research or education should be deducted from total

hospital expenses to the extent that expenditures for such items have been included in the total cost.

COMMENT . . . *It appears justifiable to include the expense of some types of applied research and basic training programs as part of the cost of hospital operation. But in the event special contributions, government subsidies, or foundation grants are made available for financing these activities, in part or in full, such amounts should be recognized in the special purpose budget to which they apply as a reduction in the gross amount of the cost of such research or educational projects. To charge the patient for an expense that was met specifically in another manner would mean that income would be derived from two sources for the same expense.*

2.304 **Bad debts, charity and courtesy allowances are not proper items of expense.**

COMMENT . . . *This principle is based on the only acceptable accounting method for calculating these items. Bad debts, charity and courtesy allowances are not expenses, rather they are deductions from income.*

2.305 **Ordinary remodeling is a charge against maintenance and repairs and should be included in expenses. Remodeling which enhances the capital value should be capitalized and therefore not included in reimbursable costs.**

COMMENT . . . *Hospitals are expected to make the necessary expenditures required to maintain the original purpose and efficiency of the plant facilities and to do minor remodeling periodically to improve the efficiency and economy of hospital operations. Such costs are properly chargeable to current operating expense. It is expected that expenditures for extensive remodeling or replacement of buildings for the purpose of enhancing the value of the hospital should be capitalized. Funds for such capital expenditures should be accumulated by regular depreciation allowances included in costs over a period of years or by some other type of financing, such as, public subscription and philanthropic contributions.*

Interest incurred on capital or other indebtedness should be included in determining "full cost." 2.306

COMMENT . . . *A hospital is a public service agency and, as such, represents a public investment in necessary community health facilities. If the public has not provided a debt-free institution, either through extended purchase of care or through public fund-raising campaigns, it must assume responsibility for the payment of debt service charges added to its bill for hospital care.*

The expense incurred by hospitals in providing services of sisters or other members of religious orders shall be accepted as an 2.307

operating expense for the determination of "full cost." The amounts included should not exceed those paid other employees for similar work and should be identifiable in the records of the institution as operating expenses.

COMMENT . . . *Inclusion of a comparable value for the donated services of members of religious orders is a recognition of their contribution to community health and welfare. Equity among hospitals requires that each institution maintain records of the amounts included in the operating expenses for such services, with a list of the individuals for whom the amounts have been calculated. The total amounts may be subdivided in the records according to whether they represent living expenses, special perquisites or salary allowances. Inclusion of such items in operating expenses implies, but does not necessarily require, that equivalent cash disbursements have been made to other agencies or to the individuals listed in the records and reports of the hospital.*

2.308 **Income received from governmental agencies, foundations or others to cover special projects or salaries paid to special employees, who ordinarily would not be employed by the hospital, should be deducted from expenses in the determination of "full cost."**

COMMENT . . . *Under some circumstances a hospital receives income from outside agencies toward the conduct of special projects or for the employment of specially trained personnel required to administer the treatment of specific types of illnesses. Agencies sponsoring such special projects or services should pay the full cost of the services sponsored on their behalf, in order that no part of the cost of these extraordinary projects need be paid by other patients, including the beneficiaries of other third-party agencies.*

"Full cost" should provide for a separate cost for the nursery care of the newborn. 2.309

COMMENT . . . *Present-day standards of specialized care for new-born infants frequently represent a substantial portion of hospital operating expenses. The cost of such care should be computed separately in order that agencies which purchase predominant amounts of maternity care may pay their proportionate share of such hospital operating costs. Such classification of expense would make possible more accurate comparison of adult patient day costs among hospitals, irrespective of the variance in the amount of care provided newborn patients. Such information should also prove useful in determining charges for self-paying patients.*

2.310 Depreciation on buildings and equipment, in accordance with recommendations of the American Hospital Association Handbook on Accounting, Statistics and business Office Procedures for Hospitals, should be included in "full cost" and should be used for replacement of the existing plant.

COMMENT . . .*The inclusion of an item of depreciation in the determination of "full-cost" is necessary to provide for the replacement of depreciated capital assets. Current business procedure does not require that all depreciation included in operating costs be accumulated and set aside in a special cash fund. The rates of depreciation for various capital assets listed in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals have gained widespread acceptance in the hospital field.*

2.311 Expenses for inpatient and outpatient services should be segregated according to the method advocated by the American Hospital Association or by a comparable method. Where this is impractical, estimated expenses for outpatient services may be computed by multiplying the total number of outpatient visits by a figure comparable to outpatient department visit costs in similar hospitals in the area.

COMMENT . . . *The payment of cost for hospital care should be related to the services rendered. When paying for inpatient care, therefore, the rates of payment should not include costs of outpatient services. As a practical matter, some hospitals do not maintain cost records necessary for accurate apportionment of expenses between inpatient and outpatient services. In such cases, an equitable and acceptable alternative procedure for determining outpatient cost is outlined in the principle. This estimated cost must be subtracted from the total cost in computing the average per diem inpatient cost for the hospital.*

2.312 Careful studies should be made of methods for adjusting general average costs to determine rates of payment applicable to particular agreements, having regard for their scope and content with respect to cases covered, accommodations used, extent of service, or other major considerations.

COMMENT . . .*There are some factors in the administration of patient care which can be identified and evaluated clearly. Examples are differences in accommodations, such as, single, double, or multiple bedrooms, differences in categories of patients, such as, chronic, aged or maternity, and differences in length of stay. Where these differences in cost can be identified and evaluated, they form a proper basis for adjustments in rates of contract payment.*

2.400 Hospitals should not be required to use income from general endowment funds or unrestricted gifts to reduce third-party payments.

COMMENT . . . *Endowment funds and gifts to hospitals are their property, and it is the responsibility of the hospital governing board to see that such funds are administered in accordance with the wishes of the benefactors or on a basis by which the hospital can best serve the community. The general financial resources of a hospital do not relieve third-party agencies of their responsibility for payment of "full cost" for services provided.*

2.401 Income from endowment funds or gifts designated by donors for the care of specific groups of third-party beneficiaries should be used to reduce third-party payments for persons in such groups.

COMMENT . . . *This principle prevents dual payments to hospitals. However, it must be interpreted with care in order that the endowment fund gift be defined specifically for the group who are the responsibility of the third-party agency. Such reductions in reimbursement from community agencies charged with the financial responsibility for general medical care of its indigent beneficiaries should be applied only to the care of the specific groups of patients for whom the gifts or endowment funds are available. It is not intended in this principle that such reductions in payment be used to affect payments from prepayment plans in which the individual has provided protection for himself through a form of insurance. Also, it is not the intent of this principle that unrestricted gifts or general endowment funds be used to reduce payments from third-party purchasers.*

3.000 OBLIGATIONS IN APPLYING PRINCIPLES OF "FULL COST" PAYMENT

3.100 When hospitals are reimbursed for "full cost," hospitals and third-party agencies have the following obligations and responsibilities:

3.101 Hospitals should assume responsibility for the provision of adequate facilities, competent personnel and high standards of service. Third-party agencies should assume responsibility for making payment for comprehensive hospital services.

COMMENT . . . *Hospital responsibility extends beyond the provision of minimum standards of patient care. Hospitals must incorporate in their health care program all essential services which high quality scientific medicine requires. Adequacy of facilities, personnel and standards of service should be judged on the basis of long-term public need rather than on short-term financial*

considerations. Likewise, third-party purchasers have a responsibility for developing programs by which all such services can be made available to their beneficiaries. Under such programs, third-party agencies must expect to pay the "full cost" of such comprehensive services in order that the hospitals can continue to provide the highest possible quality of service.

3.102 Hospitals and organized groups, in cooperation with third-party agencies, have responsibility for making studies which will lead to constant improvement in administrative and professional practices in both hospitals and third-party agencies. Such studies should be conducted for their educational value rather than for the purpose of establishing arbitrary controls.

COMMENT . . . *This principle does not intend that hospitals and third-party agencies shall conduct independent studies of each other's management, but that the two shall make joint studies of subjects of mutual concern and benefit. As the principle states, such studies will have educational value for the entire community as well as for the agencies concerned.*

3.103 Hospitals and third-party agencies should cooperate in the study of such factors as admission, length of stay, extent and amount

of services provided, and other factors that affect the cost of services to agencies purchasing care, with a view to economical and efficient use of funds.

COMMENT . . . *The consideration of any factors which would tend to reduce the cost of hospitalization without sacrificing quality of care should be of mutual interest to hospitals and third-party purchasers. Continuous study of statistics and data bearing on hospital cost and third-party purchasers' experience should be carried on to promote all possible operational savings and benefits which will inure to the patient, the hospital and the third-party agency.*

3.200 There is mutual responsibility on the part of hospitals and third-party agencies for making available, upon request, such fiscal and administrative statistics and data as are necessary for a continuing agreement on amount of payment and services provided.

COMMENT . . . *A purchasing agency has responsibility to demonstrate on occasions that its stewardship of funds is defensible. Further, the purchasing agency must have access to data regarding the product for purposes of defending such stewardship. Inasmuch as the third-party agency must secure adequate funds for hospital reimbursement, current and accurate data are required for predicting the amount of funds neces-*

sary for the agency to meet its obligations. For these purposes of mutual need, it is necessary that both hospitals and third-party agencies make fiscal and administrative statistics and data available for mutual study and understanding.

3.201 Hospitals receiving payment on the basis of "full cost" agreements should provide accurate cost data which are capable of verification by those third-party purchasers with whom they have such agreements.

COMMENT . . . *Third-party purchasers must obtain adequate cost information from hospitals to which they are paying "full cost" in order to justify the payments they make for hospital care provided their beneficiaries. Such cost information must be kept in a clear and concise form which can be readily analyzed. It is a desirable practice to have an audit of the accounts of an enterprise by qualified, disinterested auditors. Such practice will insure the provision of accurate cost information and is evidence of good faith and sound management.*

3.202 Hospitals are urged to organize in sectional or regional groups so that they may participate in joint service for uniform accounting, reporting and community planning.

COMMENT . . . *Uniformity in accounting, reporting and planning can be achieved*

through joint efforts and formally established lines of communication among hospitals. The promotion and development of uniform accounting and statistics, as outlined in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals, as well as many other projects, have been conducted successfully by metropolitan hospital councils, and by state or regional hospital associations.

Assumption of initiative in cooperation with appropriate agencies to develop objective criteria for evaluation of scope and quality of services of hospitals and third-party agencies is the logical responsibility of the American Hospital Association. **3.300**

COMMENT . . . *The mutual interest of hospitals and third-party purchasers in the production and distribution of high quality hospital care suggests the need for a continuing program of self-analysis to insure progress toward common objectives. The American Hospital Association is the logical agency to assume this undertaking, since it follows the established policy of the Association, as evidenced by its sponsorship and participation in a program of hospital accreditation and standardization.*

Ceilings on the amount of payment are not inconsistent with the principle of "full cost" and may be established through conference **3.400**

Exhibit 35

between third-party agencies and contracting hospitals.

COMMENT . . . *Most variations in per diem operating costs among hospitals can be explained satisfactorily by one or a combination of influencing factors. Some variations from the norm, however, result from failure to provide an acceptable service, provision of luxury non-essential services, or poor administrative control. Purchase of care at any price cannot be justified in the instance of hospitals which provide inadequate service. Neither can excessively high rates be justified for payment to hospitals whose administrative policies have resulted in inordinately high costs.*

Exhibit 40

SCHNADER, HARRISON, SEGAL & LEWIS

(Letterhead)

September 26, 1975

Allen W. Stewart, Esquire
Morgan, Lewis & Bockius
2107 The Fidelity Building
Philadelphia, Pennsylvania 19109

Dear Allen:

Enclosed is a copy of my letter of September 25, 1975 to all hospitals represented by DVHC in the current Blue Cross negotiations.

As you can see, I have directed the hospitals to provide Blue Cross with the information requested by both Dr. Baker and George Gannon. I have indicated in the letter that you assured me the information requested by Dr. Baker was being obtained for the sole purpose of establishing the interim per diem rate and would have no effect on final settlement for fiscal 76; and that Gannon is not seeking the information to apply any ceiling to the final settlement for fiscal 75.

If you disagree with either statement in the letter, please let me know as soon as possible so that I can determine whether or not it will be necessary for me to request a meeting with Judge Reed.

With best regards,

Sincerely yours,

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
For SCHNADER, HARRISON, SEGAL & LEWIS

Exhibit 40

SCHNADER, HARRISON, SEGAL & LEWIS

(Letterhead)

September 25, 1975

TO: HOSPITALS REPRESENTED BY DVHC IN CURRENT BLUE CROSS NEGOTIATIONS

1. As a result of the hospitals submitting fiscal 76 budgets to Blue Cross, certain hospitals are receiving a Blue Cross form letter from Doctor Baker which includes a form entitled "Detail of Adjustments". This information is allegedly needed to determine whether the imposition of the Medical School "cost ceiling" will affect your institution.

The letter invites your comments to two suggested approaches: (1) meet and negotiate a "cost ceiling" with respect to the 1976 budget or (2) Blue Cross will apply the Medical School "cost ceiling" to determine the fiscal 1976 interim per diem rate for your hospital.

Blue Cross' attorney has assured me that the sole purpose in obtaining the information is to establish the interim per diem rate and will have no effect on final settlement. On this basis, you should:

(a) Provide the requested information, and

(b) Not meet with Blue Cross to negotiate a "cost ceiling".

2. Hospitals are also receiving a memo from Mr. Gannon of Blue Cross containing instructions and two sets of Revised Blue Cross Cost Report forms for the submission of your June 30, 1975 Blue Cross Cost Reports, plus a form entitled "Detail of Flow-Through Costs FYE 6/30/75." Blue Cross' attorney has assured me that the only purpose for requesting the flow-through information

Exhibit 40

is to set the 75 flow-through information against the 1976 flow-through information; that they intend to fully abide by the Crozer settlement and pay the "full reasonable costs" for 1975 and that Blue Cross is not seeking the information to apply any "ceiling" to the final settlement for fiscal 1975. Accordingly, we recommend you provide the flow-through information requested.

3. Some hospitals are receiving requests from former patients for a refund of money paid by the patient. Since Blue Cross is deducting everything they have paid to all subscribers whether the subscriber has paid the hospital or not, we recommend you notify anyone making such a request that until the Courts resolve the Constitutionality of Act 94, there is no way to determine what refund if any they are entitled to and that as soon as it can determined they will receive it.

Sincerely yours,

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
For SCHNADER, HARRISON, SEGAL & LEWIS

BLUE CROSS OF GREATER PHILADELPHIA
1333 Chestnut Street, Philadelphia, Pennsylvania 19107

(Letterhead)

October 6, 1975

TO: The Chief Executive Officer of Each
DVHC Represented Hospital

By my letter dated September 23, 1975, you were advised that, as part of the implementation of Public Act No. 94, we are reviewing fiscal 1976 budgets in order to

Exhibit 40

establish interim rates as soon as possible. In that regard, we invited your comments as to a methodology which would avoid the freezing of interim rates, as contemplated by the 1972 Amendment to the 1971 Hospital Agreement.

Subsequent to the delivery of the September 23 letter, our attorneys were requested by Frank H. Abbott, Esq., counsel to the Delaware Valley Hospital Council, to advise as to whether or not any ceilings would be established on final settlements. In short answer, the letter of September 23, 1975 dealt only with the establishment of interim rates and does not affect the final settlement of any fiscal year.

With regard to final settlement, you are aware, a formal settlement was entered into by us and the DVHC represented hospitals as a result of the litigation instituted in the Court of Common Pleas of Delaware County known as, *Crozer-Chester, et al.* v. *Blue Cross of Greater Philadelphia,* No. 9799 of 1974. In that Agreement, specific provision was made in paragraph 4 for settlements at the end of the run out period referred to in that document. In other words, final settlement will involve payments to you for "full reasonable costs" which, of course, as determined by the circumstances, might be greater or less than the interim rates. It is, and always has been, our intention to fully conform with that Agreement and Public Act No. 94 with regard to the fiscal years affected by the Agreement and legislation.

I trust the foregoing clarifies the questions raised by your counsel. However, if you have any inquiries with regard to your individual situation, please feel free to contact this office.

Very truly yours,

/s/ Howard W. Baker

Howard W. Baker, M.D.
Vice President

Exhibit 41

BASIC ADVANCES

Abington	$ 261,652.00
All Saints	5,231.00
Bryn Mawr	227,000.00
Bryn Mawr Rush	6,800.00
Chestnut Hill	115,633.00
Delaware County	153,960.00
Doylestown	37,301.00
Episcopal	140,000.00
Frankford	114,810.00
Germantown	122,033.00
Holy Redeemer	203,530.00
Jeanes	101,260.00
J.F.K.	65,000.00
Lankenau	327,457.00
Magee	15,937.00
Memorial of Roxborough	160,654.00
Methodist	145,484.00
Mercy Catholic	314,002.00
Montgomery	92,896.00
Nazareth	192,757,00
Northeastern	122,414.00
Paoli	64,345.00
Phoenixville	51,942.00
Presbyterian	140,985.00
Riddle	132,763.00
St. Christopher's	82,276.00
St. Joseph's	43,004.00
Sacred Heart General	89,732.00
Sacred Heart (Norr.)	95,092.00
Suburban General	59,264.00
Taylor	56,446.00
West Park	83,112.00
Wills Eye	67,177.00
	$3,502,779.00

Exhibit 41

SUPPLEMENTAL ADVANCES

Mercy Catholic Medical Center	$ 314,002.00
St. Christopher's	82,276.00
Total	$3,899,057.00

Exhibit 42

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Docket No. R75-9-22

IN THE MATTER OF:

RATE FILING OF BLUE CROSS OF GREATER PHILADELPHIA FOR RATE ADJUSTMENTS OF JULY 31, 1975.

Filing Nos. 2-P-75; 3-P-75; 4-P-75; 5-P-75.

ORDER AND ADJUDICATION

AND NOW, this 16th day of October, 1975, William J. Sheppard, Insurance Commissioner of the Commonwealth of Pennsylvania makes the following Order and Adjudication:

It is appropriate to mention at this time the contract dispute between the Delaware Valley Hospital Council and Blue Cross of Greater Philadelphia. The construction of the contract has been a matter of considerable dispute and discussion among the parties and the Insurance Department. The Department is hopeful that a viable agreement will be reached in the reasonably immediate future which will encompass, among other things, appropriate methods of cost control and utilization review.

Due to the emergency nature of the subject rate request, the rate request will be approved as filed. The Department cautions Blue Cross of Greater Philadelphia, however, to exercise a greater degree of care in the future concerning the timing of their request for rate relief. It is appropriate to note at this time that Blue Cross of Greater Philadelphia requested and received their last rate increase for Non-Group and Non-Credible Group business in 1972; obviously, the three-year interval was too long a delay.

Exhibit 42

CONCLUSIONS OF LAW

1. The Insurance Commissioner has jurisdiction over the parties and the subject matter of this proceeding.

2. Proper notice of this proceeding was given.

3. The proposed filing meets the requirements for approval pursuant to 40 Pa.S. § 6124.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, IT IS ORDERED THAT:

Effective October 15, 1975, Filing Nos. 2-P-75. 3-P-75, 4-P-75 and 5-P-75 are approved for an increase of 35.0%.

/s/ WILLIAM J. SHEPPARD

WILLIAM J. SHEPPARD
Insurance Commissioner

Exhibit 43

LISTING OF HOSPITALS WHICH HAVE EXECUTED THE 1974 AGREEMENT

American Oncologic Hospital
Childrens Hospital
Community Memorial Hospital
Delaware Valley Hospital
Albert Einstein Medical Center
Friends Hospital
Graduate Hospital
Grand View Hospital
Hahnemann Medical College Hospital
Hospital of the Home for the Jewish Aged
Hospital Medical College of Pennsylvania
Hospital Philadelphia College of Osteopathic Medicine (Barth Pavillion)
Hospital University of Pennsylvania
Thomas Jefferson University Hospital
Lower Bucks Hospital
Metropolitan Hospital
Moss Rehabilitation Hospital
North Penn Hospital
Northwestern Institute of Psychiatry
Pennsylvania Hospital
Pennsylvania Institute
Philadelphia Psychiatric Hospital
Pottstown Hospital
Quakertown Hospital
St. Agnes Hospital
St. Luke's & Children's Medical Center
St. Mary—Philadelphia
St. Mary—Langhorne
Temple University Hospital

Exhibit 44

BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

Public Hearing Regarding
BLUE CROSS
of
GREATER PHILADELPHIA

Wednesday, March 17, 1971
Room 296 City Hall
Philadelphia, Pennsylvania
9:00 a.m.

PRESENT:

For the Pennsylvania Insurance Department:

HERBERT S. DENENBERG, Ph.D., Commissioner
JOHN J. SHEEHY, Director, Bureau of Rates
ROBERT A. MILLER, ESQ., Chief Counsel
RODNEY PYFER, Special Assistant
PAUL HENNING, Staff Actuary

For the Blue Cross of Greater Philadelphia:

THOMAS F. MANLEY, President
BRUCE TAYLOR, Executive Vice President
DONALDSON CRESSWELL, Chairman, Board of Directors
ROBERT H. YOUNG, ESQ., General Counsel
JAMES S. FEIGHT, ESQ., Staff Counsel

COMMISSIONER DENENBERG: Mr. Taylor, would you like to proceed?

Exhibit 44

MR. BRUCE TAYLOR: Yes, sir. Copies of my statement will be available when I am finished.

There is submitted with my testimony a volume containing our emergency interim rate filing, our merit rating adjustments, an explanation of the merit rating adjustments and various other statistical data. I should note at the outset that none of these rate increases apply to the over-65 age group who are eligible for Medicare.

Because you have directed us to keep our presentation brief, I do not plan to review these documents. It should be understood, however, that they are part of this record, that they have been prepared under my direction and supervision, and that I affirm as a part of my evidence the facts which are set forth in them.

By a letter dated February 8, 1971, you directed approximately 54 questions to us and we have prepared answers to them in writing. These are included in a second volume supporting my testimony.

As an aid to your understanding of our rate problem, we have sought to consider the entire hospital care problem in depth and I hope to present an analysis of the more significant aspects of that problem. Our study leads us to propose a number of substantial changes in present procedures. However, each recommendation will involve repercussions throughout the health care field which must be recognized before the recommendations are adopted or implemented.

As Mr. Cresswell has noted, Blue Cross rates are based on two primary factors; namely, the level of hospital costs and the frequency or incidence of benefit usage by subscribers.

In the area of incidence we have established our own review board of doctors to weed out cases of abuse. We have also required hospitals to establish their own medical review boards. We have made changes in the Blue Cross

contract to encourage outpatients' services, particularly in the diagnostic field.

We have established co-pay features to place some financial responsibility for use on the subscribers. We have conducted a continuous education program directed at the medical profession, hospital staffs and subscribers to discourage unnecessary use of hospital services. We believe that our efforts in this area have been singularly successful.

Until 1970 the Plan, partly due to Medicare, had not experienced a rise in incidence of use for over three years and in some categories incidence had actually declined.

In 1970 our incidence has risen, largely as the result of the co-pay preferred contract which we were required to adopt by the Insurance Department. By raising the available days from 30 to 70 and by expanding outpatient service, this contract made available substantially expanded benefits to subscribers and they have used those additional benefits.

The basis for the requested emergency rate relief rests exclusively in this rise in incidence. Were it not for that rise, our projections in 1969 would have proved accurate and we would not be operating in a deficit position at this time. Perhaps this experience highlights the danger of precipitous action by the Insurance Department.

With respect to hospital costs, Blue Cross converted its hospitals to a cost type contract of the variety which has been approved and from time to time urged upon it by the Insurance Department.

Under that contract a uniform cost accounting procedure for determining cost is employed, the procedure being the same for Blue Cross as it is for the Federal Government Medicare payments and State Government Title 19 payments.

The costs which hospitals incur are not paid by Blue Cross until independent auditors have thoroughly examined the hospital's records and satisfied themselves that the costs were in fact incurred, and were related to inpatient care. You should know that the adjustments made through this procedure annually are substantial.

The present cost contract also incorporated incentives designed to encourage hospitals to curb or reduce their cost levels. It is impossible to evaluate the extent to which some of the newer incentives have been effective in producing savings in hospital costs. However, we believe that all steps to verify hospital costs and to encourage voluntary control of hospital costs have been taken.

If the protection of public interest is to be expanded, then it must be through the establishment of specific involuntary controls over the costs which hospitals incur. Before discussing any such changes, however, one fact should be recognized. The overwhelming cause of hospital per diem costs rising in the past five years has been increases in the pay scales of hospital employees.

As we have said on prior occasions, hospital employees were substantially underpaid and much of this increase has been necessary to bring them to a level comparable with other members of our nation's working force. The extent to which hospital employees receive further wage increases beyond the level now existing is a matter for hospital management and labor negotiations.

Blue Cross is not a participant in that collective bargaining operation and has no authority to make itself a party. Moreover, we have no expertise in the wages of hospital employees.

So much for the hospital costs which we cannot control. What are some of the areas where some control over hospital cost may be possible? Hospitals must be paid their costs if they are to survive, and therefore our in-

quiry must concern itself with areas where costs can be controlled so as to reduce them. A number of areas immediately suggest themselves.

First, some means should be established to control the costs which are paid for facilities or programs which are not adequately utilized.

Second, and related to the first, some method must be devised to eliminate excessive beds in this area since they encourage the delivery system to fill them and thus create costs which under more restrictive conditions might be eliminated.

Third, the entire question of employee numbers requires control to insure that each hospital does not have excessive numbers of salaried physicians, interns, residents, nurses, paramedics, and general employees per patient.

Fourth, and related to the third, the entire system of financing medical education requires study and control since many hospital costs, including the costs of residents and interns, are laregly attributable to medical education.

Fifth, the propriety of depreciation allowances as a part of hospital cost needs analysis, particularly the present practice of allowing accelerated depreciation to hospitals which elect such a procedure.

Sixth, the pressure for pre-admission testing, for the efficient use of facilities, for progressive patient care and for alternates to inpatient care needs to be increased so that each hospital is not free to pursue such programs or ignore them at its pleasure.

Seventh, pressures on hospitals to control the average length of stay for standard procedures and to implement more effective utilization review procedures should be increased. Prolonged length of stay is one of the major problems contributing to the excessive hospital costs in this community.

Before discussing the implementation of these various possibilities by Blue Cross, certain general considerations need to be recognized, however.

First, these changes are unlikely to be wrought through voluntary changes in the Blue Cross-hospital contract. Our past experience makes it clear that hospitals simply won't agree to such changes on a voluntary basis. To inflict such terms on hospitals will remove many of them as providers under our contracts. As a result, our subscribers will be restricted to non-member indemnity benefits, a serious burden on them.

Second, Blue Cross regulation of hospital cost raises serious internal problems. Hospitals vary infinitely and general standards applicable to all cannot be fixed fairly. Differences in plant, in the type of cases, type of medical practice and many other factors affect their cost. To consider these multiple factors properly would require a major expansion of the Blue Cross staff.

Moreover, Blue Cross, even with an expanded staff, is not peculiarly fit for this decisional process. It has no expertise in many of these areas. Moreover, as the payor, Blue Cross decisions could be biased by its interest in reducing its own payments.

Third, decisions on most areas of hospital cost control will have profound influence on the entire health care delivery system. To suggest that such decisions should be exclusively in the hands of a single purchaser of health care is clearly foolhardy. Blue Cross personnel can claim no infallability in this field, nor even special training where medical practice or hospital procedures are involved. Obviously, and without false modesty, this role should not be exclusively ours.

Fourth, legal authority is required to produce involuntary changes in the health care system as it exists today. The changes must be made uniformly in all

hospitals and among the entire medical profession; they must be backed by the financial efforts of the community; and they must have the support of the public in their capacity as patients as well as subscribers to Blue Cross.

Such uniformity can only come through governmental supervision based on law, and not the indirect pressure of changing Insurance Commissioners through a variety of Blue Cross entities.

Finally, it must be recognized that Blue Cross is not the only payor in the health care field and whatever it may recommend cannot possibly prevail if Medicare and Medicaid follow other practices. To date neither the State nor the Federal Government has shown any capacity to provide realistic control of hospital costs.

So much for the general principles.

Blue Cross hereby submits the following proposals deemed most worthy of immediate consideration. In the development of these suggestions, we are well aware of the fact that some proposals will require providers of care to sacrifice certain prerogatives which they heretofore have regarded as rights in the name of cost containment for the benefit of the entire community.

One, licensing legislation. We recommend that the Legislature consider the development and adoption of new licensing legislation which would have as its primary objective protection of the public against unwarranted hospital costs.

Elements which should be included in this legislation are:

(a) Prior approval of the Secretary of Health for the creation of or expansion or replacement of any hospital facility.

(b) Prior approval of the Secretary of Health for any new program of hospital patient care services.

This would prevent any expansion of programs or patient care services without an independent review of the community's need.

(c) Periodic re-certification by the Secretary of Health of the public necessity for the continuation of each existing hospital service. This would routinely eliminate any services having abnormally low usage, such as excessive pediatric or obstetrical beds, underutilized special services for open-heart surgery, high-energy radiation, et cetera.

(d) Prior approval of the Secretary of Health of any capital expenditure in excess of $100,000 for capital renovations or improvements to plant or purchase of equipment.

The Secretary of Health in carrying out these responsibilities State-wide could obtain recommendations of a local independent agency such as the Hospital Survey Committee in the Delaware Valley area. Pending such legislation, we are prepared to seek voluntary acceptance in the hospital contract of a licensing procedure to function through the Hospital Survey Committee.

Two, development of public policy regarding the co-mingling of the cost of education or research with patient care.

Philadelphia has six medical schools, more than any other city in this country. Nine of our larger hospitals are controlled by or operated in conjunction with these medical schools. Additionally, these medical schools have educational affiliations with many of the area's larger hospitals.

In all such hospitals, as well as in some non-affiliated hospitals, the cost of graduate medical education of intern and resident physicians is co-mingled with patient care.

Exhibit 44

The direct expense alone related to this educational cost varies from approximately $1 per patient day in non-affiliated hospitals to $10 per day in medical school hospitals. For all of our hospitals it currently amounts to $25 to $30 million annually. Moreover, it has been increasing at an alarming rate.

These costs do not include the increasing indirect expenses attributable to, one, salaried physician directors of medical education necessitated by the numbers of interns and residents; two, the unknown expenses related to medically unnecessary or duplicated tests resulting from these educational programs; three, the additional days of hospital care resulting from medical teaching programs.

The high average length of stay for hospitals with major teaching programs is discussed in our responses to the Insurance Department questions. While these indirect expenses do not lend themselves to precise measurement, it can be conservatively estimated that they are of the same magnitude as the direct expenses, an additional $25 million to $30 million annually.

While it is generally recognized that there is a national shortage of physicians, it is less common knowledge that excluding osteopathic residents, the percentage of medical residents who are foreign citizens has been estimated by informed sources to be in excess of 50 percent. These student physicians are here for educational purposes only and upon completion of their studies, many will return to their native land.

The medical schools of this area have a long and impressive history in education and development of medical technology. In fact, Philadelphia has been called "The World Capitol of Medical Education". But, since the community's rise in the cost of hospital care has been accelerated both by direct and indirect educational costs, the financing of medical education as a tax on the community's hospital bill must be re-examined.

Exhibit 44

We recommend immediate study, either by the Legislature or the existing State Board of Medical Education and Licensure, or both, to promulgate standards for the number of interns and residents, if any, that consumers of hospital care should reasonably be expected to support as a cost of patient care. Such standards of necessity must be accompanied by appropriate regulation which would exclude from hospital cost and patient charges any expense directly or indirectly related to any interns or residents in excess of the approved complement.

A corollary to educational programs are research programs which involve patient care. Such programs are particularly extensive in medical school hospitals and also serve to inflate the cost of hospital care.

While the direct cost of research is not presently recognized as a reimbursable expense, projects which are intertwined with patient care are included in consumer cost rather than being charged back to the sponsors of the research. We recommend that appropriate regulation be developed establishing standards for the control of this expense.

Pending community decision on this issue, we are prepared to press hospitals for standards designed to control the costs to our subscribers which are associated with medical education.

Three, establishment of public control of hospital staffing patterns.

During the past three years, with notably few exceptions, hospitals of the Delaware Valley area on the average have successively increased their personnel complement. This increase has far outstripped any expansion of patient care services. The salaries and wages of these additional employees account for a substantial increase in total payroll expense.

In order that the public may have adequate assurance that these additional employees, as well as future increases, are necessary and represent a justifiable increase in operating expenses, we recommend the consideration of appropriate regulatory legislation. The objective of such legislation would be to require prior approval of the Secretary of Health for any future increase in employees necessitated by expanded patient services, and would also require a re-evaluation of those increases which have taken place since 1967 with an appropriate roll-back of any unwarranted additions. The Secretary could act on the basis of recommendations of a designated independent local agency such as the Hospital Survey Committee, Incorporated.

Obviously such legislation would require regulations which would make adjustments for the discontinuance of any services, decreases in occupancy rate, elimination of non-conforming beds, or other reductions in bed complement, subcontracting of functions or services, et cetera.

It is impossible, at this time, to determine the effect that such a program would have on the community's total hospital bill, but it is apparent that a significant portion of the annual increases in payroll stem from this source.

Pending necessary legislation in this area, we are prepared to urge upon the hospitals every possible analysis of this problem and to work with the Hospital Survey Committee to bring about voluntary control in the area.

Four, public re-evaluation of the acceptance of depreciation as an element of hospital cost.

The voluntary hospital system was established primarily through philanthropic tax-free gifts and government grants. These funds were contributed for the purpose of establishing hospitals which would have the ability of providing necessary care to the sick of the community. To include depreciation in the cost of hospital care is to

place a charge on the sick people for the use of the facilities which were voluntarily established for their care.

It has a further connotation, that irrespective of how future patterns of care may be modified through technological developments or population shifts, the patients currently using the hospitals have a financial responsibility for the replacement of the contributed capital assets regardless of what the future community need may be.

Many hospitals in this area operated for decades without considering depreciation as an element of the cost of patient care. The Commonwealth itself never recognized this aspect of cost in its various programs of financing hospital care for the needy, until the advent of the Medical Assistance Program.

We recommend that the Legislature give consideration to the appropriateness of the acceptance of depreciation as an element of cost for our voluntary hospitals. Such consideration should recognize that in the event the public policy which is established eliminates depreciation, it would be appropriate to include in cost approved non-operating expenditures for renovations and equipment spread over a reasonable period of years and other approved capital charges, such as amortization of capital indebtedness, as prescribed by appropriate regulations.

Since hospitals in this area have become accustomed to defining cost to include depreciation, not only for Blue Cross reimbursement but for reimbursement by the State and Federal Government and paying patients, we believe that if it is found to be an inappropriate element of cost to be borne by the consumer-patients, we question whether its exclusion can ever be achieved without the compulsion of law.

The amounts being added for depreciation to the direct operating expenses of contracting hospitals vary widely from a low of $1.12 per patient day to a high of

$9.81 per patient day. Depreciation alone currently adds more than $26 million to the community's total hospital bill, and this amount is escalating rapidly. Pending definitive state action, we will press for a change in our hospital contract to eliminate depreciation.

Five, elimination of unnecessary substandard hospital beds.

It is an established fact that the average stay in this Metropolitan area is longer than any city in the state and the longest of any Blue Cross Plan in the United States serving more than 1 million subscribers. This can be seen from the following table which shows Philadelphia with an average stay for persons under 65 in 1969 of 8.50, graduated down to a low of 6.11 in the Louisville, Kentucky, Plan, with the average for all such plans being 7.35.

Despite the many programs and incentives which Blue Cross has poineered to shorten the average stay, with relatively few exceptions, they have not accomplished their objectives. It is a well known axiom that whenever hospital beds are available they tend to be used.

Dr. Eli Ginsberg, Professor of Economics at Columbia University, expressed it this way in a recent articles entitled, "Hospital Costs: Sense and Nonsense": "If one remembers Roemer's law that all beds tend to be used, there will not be even any payoff in my opinion for better professional control over admissions and discharges, or any significant gains through incentive reimbursement policies unless and until tight control is exercised over the total bed complement."

We do not believe that the excessive length of stay in this area can be effectively reduced until tight control over the total bed complement is achieved.

It is also an established fact that many of the hospital beds in the Philadelphia area do not meet the fire

and other safety standards of the Office of Medical Services and Facilities of the Commonwealth and have been classified by that agency as "Non-Conforming Beds". Yet hospitals have been permitted to continue to use these beds for acute care inpatients and this has helped to continue patterns of excessive hospitalization.

If physicians and hospitals generally were obliged to fully implement many of the known cost containment techniques, such as pre-admission testing, establishment of short procedure units, hospital-based home care programs, progressive patient care, planned patient discharge, extension of the hospital work week, use of outpatient facilities as an alternative for inpatient stay, improved occupancy ratio, et cetera, the present bed complement in this area could be reduced, without adversely affecting the availability of facilities for necessary care.

We believe that the State Office of Medical Services and Facilities through close consultation with the Hospital Survey Committee could achieve a reduction in bed complement of as much as ten percent to twenty percent initially. Such a reduction would not only give patients greater protection against the known hazards of continued use of some non-conforming beds, but would also substantially reduce the community total hospital bill through a shortening of the average length of stay coupled with a more effective use of the community's hospital facilities.

We further believe that some of the beds withdrawn from acute care could through renovation be converted to extended care or custodial care facilities, the creation of which would further reduce the average length of hospital stay by providing suitable alternate facilities for the early transfer of patients when the acute phase of their illness has been met. A reduction in the total bed complement of ten to twenty percent would reduce the total hospital bill for this community by $30 million to $45 million annually.

Exhibit 44

We plan to press for a reduction of bed complement through our hospital contract pending effective state action.

Finally, in more general areas, we plan to pursue the extension of limits on the length of hospital stay in our subscriber contracts for standard surgical procedures and to press hospitals to fix standards in these areas. We also plan to exert additional pressure on hospitals to improve the performance of their utilization review committees, to establish pre-admission testing, and to avail themselves of efficiency studies.

In conclusion, the areas for study which we have suggested here are directed primarily toward fundamental changes in our health care delivery system. These suggestions have the potential for reducing this community total hospital bill by $50 million to $100 million annually. They would for years overcome the annual increases in hospital costs which cannot be controlled. Blue Cross share in this saving would be on the order of 30 percent.

In conclusion, we acknowledge that there are problems in our system of delivery of health care. To my knowledge, no other service in our community is delivered under a system in which the customer's health determines when he needs service; a second party, the physician, determines how much service he needs; a third party, the hospital, provides the service up to the quantities and for the length of time determined by the physician. The hospital is then paid whatever its costs were for the service by a fourth party, Blue Cross, and that fourth party seeks to collect from the fifth group, the subscribers.

Since the subscribers are obviously not all patients, it is clear that the economic circle is never closed. Responsibility for the costs incurred is avoided by each of the groups, except the last. Moreover, none of the parties has any real control over the previous party whose decisions caused his activity.

Exhibit 44

We have come to recognize that in attacking the flaws in this type of system there is no panacea which will guarantee solution. However, means for establishing responsibility for hospital care costs all along the line must be developed. Blue Cross now re-states its continued dedication to its subscribers' interest. The fundamental purpose of Blue Cross in Philadelphia is, and always has been, to provide its subscribers a viable method of financing their hospitalization needs.

In this role it serves as a bridge between its nearly 2,400,000 subscribers and those 890,000 occasions in 1970 on which it provided benefits to those subscribers. If the underpinning of this Blue Cross bridge is further impaired through improvident restriction on its finances, its ability to serve both the consumers who require hospital care as well as the consumers who finance that care will have been destroyed, and both consumer groups will be denied this facility for prepaying their hospitalization needs.

COMMISSIONER DENENBERG: Thank you very much, Mr. Taylor.

MR. TAYLOR: Mr. Commissioner, I have certain charts here which I would like to present at this time for the benefit of the Insurance Department Staff and the public who are assembled here.

COMMISSIONER DENENBERG: Fine.

(The charts were brought forward and set up on an easel.)

MR. TAYLOR: This particular chart illustrates the dollar change over a long period of time which has taken place in Blue Cross premiums, which is the bottom line here, from 1947 through 1970, which shows a rise in premiums here through the present level which is about $25 per month for a family contract.

The various other lines indicate the average monthly wages for various types of workers as are illustrated there, the bottom being the wholesale and retail industry, service industry, finance, manufacturing, mining, transportation, and at the top construction.

But the chart largely illustrates that not only while Blue Cross has been affected by inflation over a long period of time, that wages have likewise been affected but also have gone up at a much faster rate.

COMMISSIONER DENENBERG: To look at that chart it looks like you're almost giving it away, the way it is set up.

MR. MILLER: Where would hospital costs fit on that chart, Mr. Taylor?

MR. TAYLOR: The hospital costs, I think, really are reflected in the Blue Cross premiums.

MR. MILLER: Would they have climbed at a much steeper rate than the premiums over that period of time?

MR. TAYLOR: I think the rate of increase is a steeper rate, but the dollars of hospital cost have not. The premiums have been adequate to cover the hospital costs.

COMMISSIONER DENENBERG: Incidentally, are these in your presentation?

MR. TAYLOR: No, they are not, but copies will be made available to the Department.

COMMISSIONER DENENBERG: Okay. Proceed.

MR. TAYLOR: This chart deals with three basic subjects. The blue bars on the chart indicate the number of claims which Blue Cross paid, and the green area indicates the dollar value of those claims.

If you notice, looking only at 1969 and 1970, in 1969 the financial value of the claims or the dollar value paid increases from $137 million in 1969 to $172 million in 1970.

You also notice that the number of claims or the occasions on which the subscribers benefitted from Blue Cross increased from 736,000 to 890,000, reflecting largely the increase in scope of coverage available to subscribers through the co-pay preferred contract.

It is also interesting on looking at the benefits which subscribers received from another direction, this chart illustrates the numbers of cases which exceeded $1,500 in benefits. You will notice that in 1967 the number of subscribers receiving hospital care benefits from Blue Cross in excess of $1,500 were 8,438. In 1970 this number had expanded to 25,708.

This illustrates the importance of Blue Cross benefits to many of our subscribers and also shows the relationship here of how small Blue Cross premiums are to how large the benefit payments may be.

MR. MILLER: How does that compare with the general increase in subscribers over that same period of time, Mr. Taylor?

MR. TAYLOR: The general increase in subscribers between 1967 and 1970, while it has increased slightly, has been relatively stable. A very small amount of the increase shown on here would be attributable to additional subscribers.

Finally, Mr. Commissioner, and perhaps most significant of all, I would like to present for you this chart which indicates what our actual reserves have been and what our projected reserve position is.

This information is included in the emergency rate interim filing.

It shows that the reserves in 1967 were $20 million. It shows that because the Plan has consistently operated since that time on an inadequate rate base, that the constant demand on reserves reduced it to a $2 million level at the end of January, and that our projections here on a

monthly basis show that by the end of July the minus amount or negative amount of reserves unless the interim rate adjustment is granted will be close to $10 million.

Thank you.

COMMISSIONER DENENBERG: May we have copies of those charts at this time for the record?

MR. TAYLOR: Yes.

Supreme Court, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MOTION TO AFFIRM

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OTHER AUTHORITIES:

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IN THE

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THE WILLIAMSPORT HOSPITAL, et al., Appellants

v.

F. EMMETT FITZPATRICK, et al.

On Appeal from the United States District Court for the Eastern District of Pennsylvania

MOTION TO AFFIRM

Pursuant to Rule 16(1)(c) of the Rules of this Court, appellees move to affirm the judgment of the district court.

STATEMENT

Central to the instant health care delivery dispute are the patient on one side and the hospital on the other. As an intermediary between the two are hospital plan corporations, many of which are known as "Blue Cross" plans.

The Blue Cross-Subscriber Contract. Blue Cross plans were established by the hospital industry itself as a mechanism to insure against the costs of hospital service. A potential hospital patient enters into a subscription contract with a hospital plan corporation (hereinafter a "Blue Cross Plan"). Under the typical subscription agreement the Blue Cross Plan agrees to provide one of two alternative types of benefits:

(a) Under the more usual arrangement, the Plan will obtain hospital services for the subscriber in a so-called "member hospital". In some cases the subscriber must pay a relatively small portion of the hospital bill as coinsurance. In other cases the full hospital service is provided by the Plan, and no payment is made by the subscriber in connection with a spell of hospitalization. The benefit under this alternative is referred to as a "service benefit".

(b) Where the subscriber is admitted to a hospital which is not a "member hospital", the Plan merely makes a cash payment directly to the subscriber in whole or partial reimbursement of his or her cost of hospitalization. Typically, this payment will be much less (perhaps as much as 75% less) than the full hospital charge. The benefit under this alternative is referred to as an "indemnity benefit".[1]

The Blue Cross-Hospital Contract. There is no need for a Blue Cross Plan to have any contractual relationship with hospitals in a community in order to provide the indemnity benefit, which, as indicated above, is ordinarily paid directly to the patient-subscriber. To provide the usually more comprehensive service benefit, however, a second class of contract is necessary, *i.e.*, between the Blue Cross Plan and the hospitals in a community. It is of major significance to this litigation that historically almost all major hospitals in Pennsylvania have been member hospitals contracting with Blue Cross. Indeed, until the recent defection of the appellants in No. 75-1691 (the Delaware Valley Hospital Council-represented hospitals), litigation had arisen in exactly this direction, *i.e.* appellee Blue Cross of Greater Philadelphia has been made a defendant for allegedly improperly refusing to admit a hospital to the widely-desired status of member hospital.[2]

Transmutation of the Blue Cross-Hospital Contract into a Hospital Cost Containment Tool. The initial

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[1] Appellants in No. 75-1698 incorrectly state (J.S. pp. 18-19) that "[n]onmember hospitals, treating Blue Cross subscribers, receive a predetermined amount from Blue Cross. . . . " Only "member hospitals" have a direct relationship with Blue Cross; in a "nonmember hospital" admission, the Blue Cross payment is made to the subscriber, *not* to the hospital.

[2] See e.g. *Doctors Hospital* v. *Blue Cross of Greater Philadelphia*, Civil Action No. 73-1057 (E.D. Pa. August 13, 1975), *aff'd per curiam*, No. 75-2166 (3d Cir. April 28, 1976).

authorization for the creation of Blue Cross Plans in Pennsylvania was given by the enactment of the Nonprofit Hospital Plan Act, act of June 21, 1937 (P.L. 1948). These provisions are now codified at 40 Pa. C.S.A. §§ 6101-6127.

Generally speaking, the laws applicable to commercial insurers are not applicable to Blue Cross Plans. 40 Pa.C.S.A. § 6103(a). A Plan may contract only with government-operated hospitals or with hospitals approved by the Department of Public Welfare. 40 Pa.C.S.A. § 6121; 62 P.S. § 1003; 67 Pa.C.S.A. § 6102; 71 P.S. § 755-2. Blue Cross-hospital and Blue Cross-subscriber contracts are subject to Insurance Department approval. 40 Pa.C.S.A. § 6124(a).

Originally, the Blue Cross-hospital contracts called for Blue Cross to pay a flat per diem reimbursement to a hospital in order to purchase hospital service required by a subscriber-patient.

As successive Pennsylvania Insurance Commissioners began to appreciate the significance and magnitude of hospital cost inflation, a governmental policy was adopted to utilize the Blue Cross-hospital contract as a vehicle to control the rate of escalation of hospital costs. This technique was feasible because over one-half of the population of the Commonwealth of Pennsylvania is covered by Blue Cross benefits.

Accordingly, the Blue Cross-hospital contracts were revised in several stages until by 1971 the hospital no longer received from Blue Cross a flat per diem reimbursement (which had always been less than the hospital's posted "charges" (or retail price)), but rather received only the actual cost (including depreciation, etc.) of providing the service to Blue Cross subscribers. These Blue Cross-hospital contracts are complex but in general provide definitions of reimbursable costs and procedures for the resolution of disputed questions (including, where necessary, ultimate court review).

It is important to note that the cost-based Blue Cross-hospital contract is open ended in that it has a built-in price escalator; that is, being cost-based, as a hospital's allowed costs increase due to inflation, the dollar amount of the hospital's per diem reimbursement from Blue Cross also increases without the need for any further revision in the basic contract.

Effect of the Unanticipated Abandonment of Member Hospital Status by the DVHC. The Delaware Valley Hospital Council (the "DVHC"), appellant in No. 75-1691, represents a group of approximately 30 hospitals which have since August 15, 1974 refused to extend voluntarily their Blue Cross-hospital contracts (contracts which have existed, in one form or another, since the inception of the Plan in southeastern Pennsylvania in the late 1930's). It was anticipated on all sides that any new contract, like all prior contracts, would take effect retroactively to the August 15, 1974 expiration of the last preceding contract. The principal impediments to a new contract are (see Exhibit B, *infra*, 51):

(a) A demand by the DVHC-represented hospitals that where the hospital does not receive full payment for services rendered to a non-Blue Cross subscriber (*e.g.,* to an indigent patient or to a physician or other person who traditionally is not charged for hospital services), Blue Cross subscribers as a class must shoulder a specified part of these costs.[3]

(b) A demand by the DVHC-represented hospitals that the existing controls over unjustified expansion of bed capacity and duplication of expensive "big ticket" medical facilities (such as open-heart surgery units, intensive care units, burn treatment units, electronic brain and whole body scanners, cancer radiation therapy, renal dialysis, etc.) be abandoned.

The effect of the August 15, 1974 termination of the Blue Cross-hospital contracts was gradually to convert the DVHC hospitals from "member" to nonmember hospitals over the period of a year. Under the so-called "run-out" provision of the contracts, the DVHC-represented hospitals were to lose their status as "member" hospitals with respect to any particular Blue Cross subscriber on the next annual renewal date of his or her Blue Cross-subscriber contract. Thus a progressively declining proportion of all Blue

[3] Indeed, appellants in No. 75-1698 candidly concede that their aim is to eviscerate the cost control efforts of Medicare, Medicaid and Blue Cross, which refuse to pay for misutilized services, thereby encouraging more efficient hospital administration. Thus these appellants seek to have Blue Cross absorb the cost of, *inter alia,* "misutilized patient days" (J.S., p. 16), thus destroying one of the principal incentives for more efficient operation.

Cross subscribers were entitled to "member" benefits in DVHC-represented hospitals, with the last group scheduled to lose such benefits on August 15, 1975 (one year after the commencement of the run-out period). The effect of this change is illustrated by the following hypothetical example:

(a) Before the run-out, a Blue Cross subscriber who experienced a 9-day spell of hospitalization in a "member" hospital with a $150 per day rate and a $120 per day "cost"[4] might have been presented on discharge with a $90 bill computed as follows:

Hospital "charges"	$150 per day
Cost of service as determined under the Blue Cross-hospital cost reimbursement formula	$120 per day
Paid by subscriber to hospital (required coinsurance under Blue Cross-subscriber contract) (9 × $10)	$90
Paid by Blue Cross to hospital	(9 × $120) − $90 = $990
Total received by hospital	$1,080

(b) After the run-out, the impact on the Blue Cross subscriber could be dramatically different, since the nonmember status of the hospital converts the Blue Cross program to a cash indemnity plan, and the hy-

[4] Appellants in No. 75-1691 suggest that the hospitals' list prices or "charges" may be as much as 40% more than their "reasonable costs" (J.S., p. 8 n. 6), but a 25% profit or markup is utilized here for illustrative purposes.

pothetical patient would be presented on discharge with a $1,350 bill:

Hospital "charges"	$150 per day
Paid by subscriber to hospital (9 × $150)	$1,350
Indemnity paid subsequently by Blue Cross to subscriber (1 × $50 + 8 × $25)	$250
Net amount ultimately paid by subscriber ..	$1,100

Response of the Commonwealth of Pennsylvania. On August 2, 1975, prior to the final run-out of the existing Blue Cross-hospital contract with the DVHC-represented hospitals, the Pennsylvania General Assembly enacted Act No. 94. The Act has the following effects:

(a) Where a Blue Cross-hospital contract was in existence on August 2, 1975, or where it is entered into then or thereafter, the contract (including primarily the cost reimbursement feature) may not thereafter be terminated without going through a "cooling-off" procedure involving notice to the Insurance Department, investigative hearing, recommendations by the Department, and further negotiations. (This is the only concern of the appellants in No. 75-1698, since they were in no way directly involved in the dispute between Blue Cross and the DVHC-represented hospitals, but had existing contracts which became subject to the cooling-off provisions of the statute. See Jurisdictional Statement in No. 75-1698, pp. 8-9.)

(b) The remaining impact of the statute was confined to hospitals which had benefited substantially continuously from Blue Cross-hospital contracts during the *ten year* base period June 30, 1964 to June 30, 1974, but which were not covered (except for the application of the run-out period) by a Blue Cross-hospital contract on August 2, 1975 (all of the DVHC-represented hospitals fall into this classification). As to these hospitals the last approved Blue Cross-hospital contract on file with the Insurance Department was made applicable to August 2, 1975 and subsequent hospital admissions until a termination of the prior contract under the cooling-off provisions described in (a) above is effected, or unless and until the prior contract is retroactively superseded by a new agreement, voluntarily entered into between Blue Cross and the hospitals and approved by the Insurance Department. Before the district court the Commonwealth and Blue Cross argued that, properly understood, this aspect of Act No. 94 was clearly prospective in effect.

(c) In the case of hospitals covered by (b) above, the last approved Blue Cross-hospital contract was also made applicable to the operations of the hospitals during the "locked-in" period between August 15, 1974 and August 2, 1975, unless and until retroactively superseded by a new voluntary agreement as described in (b), above.

Returning to the earlier hypothetical example, if Act No. 94 had been drafted simply as a price control statute, the Blue Cross subscriber who expected

to pay $90 on discharge would still have found it necessary to pay a net of $830 for his or her spell of hospitalization:

Hospital "charges" before controls..	$150 per day
Hospital "charges" as determined under Blue Cross-hospital cost reimbursement formula adopted by Act No. 94.....	$120 per day
Paid by subscriber to hospital (9 × $120) =	$1,080
Indemnity paid subsequently by Blue Cross to subscriber (1 × $50 + 8 × $25)	$ 250
Net amount ultimately paid by subscriber	$ 830

By characterizing the Blue Cross-hospital contract as "reinstated," Act No. 94 gave the DVHC-represented hospitals "member hospital" status under the separate Blue Cross-*subscriber* contracts, thus, in the hypothetical example, restoring the Blue Cross-paid portion of the hospital bill to $990 from $250 and reducing the subscriber-paid portion from $830 to $90.

In the district court the Commonwealth and Blue Cross argued (1) that the hospitals involved were not constitutionally affected by this contract reinstatement characterization, since it in substance affected only the separate relationships between Blue Cross and its subscribers, and (2) that thus stripped of its "contract clause" overtones, the issue before the district court was simply whether the Commonwealth of Pennsylvania could constitutionally impose cost-based price controls on the hospitals for the future and with respect to the August 15, 1974-August 2, 1975 locked-in period.

ARGUMENT

A. BACKGROUND

The Magnitude of the Crisis Facing the Legislature was Great. On a National level, health expenditures over the period 1950 to 1975 have almost doubled as a percentage of Gross National Product (4.6% to 8.3%) and of personal income (5.7% to 9.9%), with further increases predicted for the future (the Department of Health, Education and Welfare estimates that by 1990, 10% to 12% of Gross National Product will be spent for health care). Hospital expenditures are even higher than overall health expenditures, so that the cost of an average hospital stay is up from $311 in 1965 to $1017 in 1975; over the same period, the average length of hospital stays declined.[5]

The situation in the area of appellant hospitals is even more egregious. Per diem hospital costs in the Philadelphia area rose from only $29.27 in 1964 to $117.83 in 1974, or 400% in 10 years, with $201.25 per diem projected for 1977 (Ex. 31).[6]

To protect themselves from exposure to this economic risk, and to assure themselves the ability to obtain adequate health care, over half the population

[5] Executive Office of the President, Council on Wage and Price Stability, Staff Report on "The Problem of Rising Health Care Costs" at 4, 9, 23, 27 (April 1976) (GPO Stock No. 052-003-00164-1).

[6] References to "Ex." herein are to correspondingly-numbered exhibits to the affidavits of Mr. Bruce Taylor, as contained in the record.

of the Commonwealth of Pennsylvania is covered by Blue Cross Plans (Taylor Affidavit, ¶ 6). Appellant Blue Cross of Greater Philadelphia alone has approximately 2,400,000 subscribers (Taylor Affidavit, ¶ 5). Thus, literally millions of residents were subjected to a severe crisis situation by the unanticipated hiatus in their hospitalization coverage.

Act No. 94 Establishes Hospitalization Rates on the Basis of an Open-Ended Formula, Not a Fixed Price. Under Act No. 94, the appellant hospitals are reimbursed on the basis of a formula which automatically increases the dollar payment to the hospitals as their eligible costs increase due to inflation. It is true, as stated by the appellants in No. 75-1691 (J.S., p. 6 n. 5), that at one time there were dollar limits in effect. But by the time Act No. 94 was enacted all such limits had been removed. See, e.g., Ex. 17, 18 and 20 as modified by Ex. 23, ¶ 4: "full reasonable costs" to be paid. Thus the statute does *not* freeze reimbursement at a fixed dollar price.[7]

The courts have recognized that the Blue Cross Plan cost reimbursement approach is an entirely appropriate and valid method of containing otherwise

[7] The dispute here is analogous to a claim that the regulated industry has a constitutional right to a "fair value" as opposed to an "original cost" rate base. Cf. *F.P.C.* v. *Hope Natural Gas Co.* 320 U.S. 591 (1944). It is the *formula* which is attacked, not a specific per diem rate for a specific hospital applicable during a specific period of time. Thus the request of the appellants for further hearing below or before a state agency (e.g. J.S. in No. 75-1691, pp. 2, 18-19, 23), is wholly inapposite, since the validity of the formula as an exercise of state legislative policy is a question of law.

unrestrained hospital cost increases, and have sustained it against challenges brought by hospitals,[8] commercial insurance carriers,[9] and non-Blue Cross subscribers.[10]

Thus, the only question is whether the formula must necessarily take into account such items as free care provided to indigents and courtesy care provided to hospital staff and their families, either by specific coverage of such items or by inclusion of an undifferentiated "plus factor" covering all such items.

The nature of the Act No. 94 formula is key to the case at bar. To be sure, a fixed price formula might tend toward the confiscatory over time, as inflation caused the underlying costs to the hospitals to increase. But that is not the case here. As noted immediately above, the formula incorporated by the statute is open ended and has a built-in price escalator, so that it adjusts automatically for inflation.

Unfortunately, the dissenting judge below seems to have misunderstood this point:

> "The effect of the Act is to force contracting hospitals to continue to provide care to subscriber

[8] *Frankford Hospital* v. *Blue Cross of Greater Philadelphia,* Civil Action No. 74-2281 (E.D. Pa.) (June 8, 1976) (a copy of the unreported decision is annexed as Exhibit A).

[9] *Travelers Ins. Co.* v. *Blue Cross of Western Pa.,* 361 F.Supp. 774 (W.D.Pa. 1972), *aff'd,* 481 F.2d 80 (3rd Cir. 1973), *cert. denied,* 414 U.S. 1093 (1974); *New Jersey Association of Independent Insurance Agents* v. *Hospital Service Plan of New Jersey,* 343 A.2d 739, 68 N.J. 213 (1975).

[10] *Borland* v. *Bayonne Hospital,* 300 A.2d 584, 122 N.J. Super. 387 (Ch. Div. 1973), *aff'd,* 344 A.2d 331, 136 N.J. Super. 60 (1975).

> patients at increasing current costs, while reimbursement from the hospital plan corporations is based on previously negotiated cost calculations and formulae . . . [S]ubscriber patients will be paying for hospital services, through the hospital plan corporation, rates which do not fully reflect the escalating costs caused by the inflationary spiral." Jurisdictional Statement in No. 75-1691, pp. A27-A28.

It may well be that had he perceived correctly the nature and effect of the open-ended cost-of-service formula, the dissenting judge himself might have joined in the majority's assessment of its validity.

The Formula Incorporated by the Statute is the Medicare Formula Which Was Developed by the American Hospital Association. The reimbursement formula codified by Act No. 94 is based on the same cost accounting principles as utilized by the Federal government in computing Medicare payments. These procedures require that all legitimate costs associated with the treatment of Blue Cross subscribers be paid by the Plan. These costs include not only payroll, medicine, supplies and meals, but also encompass maintenance expenses, depreciation, and interest on borrowed funds. The formula adopted by Act No. 94 incorporates by reference the appropriate Medicare rules, regulations and interpretations, which provide in detail procedures to be utilized by independent certified public accountants in fixing final payments.

The Medicare program is based on the principle that the costs attributable to a given patient should

be borne by that patient or the third-party payor responsible for reimbursing the hospital for services rendered that patient. In developing the extensive procedures necessary to accomplish this result, Congress, and the Secretary of Health, Education and Welfare, borrowed substantially from the "Principles of Payment for Hospital Care" approved by the American Hospital Association in September, 1953 (Ex. 35). Although appellants assert that the Plan should bear the costs attributable to providing care to indigents, uncollectible amounts other than those of Blue Cross subscribers, providing charity allowances and underwriting certain educational and research activities, the 1953 AHA Principles state such is improper.

Thus, appellants would erect as their constitutional prerogative a right to include within the formula payments which even their own Association conceded was improper at the time Medicare was first enacted.

The Formula Incorporated by the Statute is Applicable Only to Hospitals Who Have Benefited Greatly from it in the Past. Except for the "cooling off" procedure objected to by the appellants in No. 75-1698, the impact of Act No. 94 by its terms applies only to hospitals which have benefited from the Blue Cross reimbursement arrangements substantially continuously for at least 10 years. To understand this point fully, one must appreciate that there exist two approaches to reimbursement of hospitals:

(a) First, there is the Blue Cross system. Under this approach, hospitals receive payment for allowable "costs", such payment being guaranteed by Blue Cross. The ability of Blue Cross to honor such guarantee is policed by the Commonwealth, which regulates reserves, rates to subscribers, etc.

(b) Second, there is the non-Blue Cross system. Under this approach, hospitals bill their full retail "charges", and collect what they can, when they can, net of collection costs, from each individual patient.

Appellants thus may forego above-cost collections in exchange for the certainty of payment, or they may charge what the traffic will bear and take the risk that the charges are uncollectible. But there is nothing in the decisions of this Court that suggests, much less requires, that a State must give the appellant hospitals the best of both worlds.[11]

The Formula is a Matter of Policy, Not Constitutionality. It should be re-emphasized that the case at bar does not deal with the question whether a cost-based reimbursement formula *may* include certain disputed items. Rather, it deals with whether the rate formula *must* include those items. The district court found that the rate formula adopted by Pennsylvania was permissible. Similarly, the Massachusetts formula

[11] The hospitals on behalf of which the DVHC negotiates have split into two groups. The hospitals represented by the DVHC in this litigation represent in the aggregate approximately one-half of the nonprofit charitable beds served by Blue Cross of Greater Philadelphia. The remaining beds are represented by the seven local medical school hospitals and certain other hospitals which, although represented by DVHC in negotiations, voluntarily settled their dispute with Blue Cross (Ex. 24, 25 and 26).

has been sustained by this Court against allegations that it failed to provide fair reimbursement for seven specific items.[12]

Moreover, it should be noted that all but one of appellant hospitals accepts Hill-Burton funds from the Federal government (Taylor Affidavit, ¶ 84), thereby obligating themselves to provide certain free care to indigents.[13] It is difficult to understand why appellants believe they have a constitutional right to collect from Blue Cross subscribers the cost of rendering the indigent care which they are required by law to provide.[14]

Other disputed omissions from the Pennsylvania formula are similar. For example, to read into the Constitution a requirement that hospitals be reimbursed for free care provided to highly compensated doctors and their families is, to say the least, novel.

To be sure, reasonable men may differ as to whether the disputed items should be reimbursed.[15] It is clear,

[12] *Murphy Nursing Home* v. *Rate Setting Commission*, 305 N.E. 2d 837 (Mass. 1973), *appeal dismissed*, 417 U.S. 962 (1974).

[13] 42 U.S.C. § 291 *et seq.* See *Corum* v. *Beth Israel Medical Center*, 359 F.Supp. 909, 917 (S.D.N.Y. 1973).

[14] Appellants in No. 75-1691 take the district court to task (J.S., pp. 19-20) for allegedly failing to perceive the charitable nature of the appellants, all of which are nonprofit charitable institutions. But it is precisely because appellants are committed to charity that they cannot, certainly as a constitutional matter, force the Blue Cross subscriber to pay for the costs of the work which the hospitals hold out as a charity. Appellants' view of "charity" smacks of a private tax levied upon those fortunate enough to enjoy Blue Cross benefits.

[15] *Compare* the positions of Insurance Commissioners Maxwell and Denenberg with the position of Commissioner Sheppard, Exhibit A at 32 n.5, 33 n.6 and 36 n.9.

however, that the question is not of constitutional proportions.

Appellants Had No Actual Expectation of Receiving their List Prices for the Locked-In Hospitalization Services. Appellant hospitals did not in fact rely on being able to charge non-subscriber rates to Blue Cross subscribers during the August 15, 1974-August 2, 1975 "locked-in" period. Although appellants in their Jurisdictional Statements claim that their reasonable expectations have been upset, this is not a case where the hospitals' conduct would have been different in fact if enactment of Act No. 94 had been foreseen from the beginning.

Under past practice, contractual agreements between appellant hospitals and appellee Blue Cross have always been made retroactive (Taylor Affidavit, ¶ ¶ 27, 32, 34, 42). Indeed, both appellees and appellant hospitals have all along taken the position that whatever agreement is reached in the current contract negotiations will be made retroactive to the August 15, 1974 expiration of the last contract between the parties.[16] To return to the earlier hypothetical example,

[16] See letter from counsel for DVHC (Ex. 29), annexed as Exhibit B hereto. Thus the argument of appellants in No. 75-1691 that the typical Blue Cross subscriber who renewed his coverage after July 31, 1974 in effect did so without justifiable expectation of coverage in a DVHC—represented hospital (J.S., p. 15 n. 12) is obviously specious. The 2,400,000 members of the general public were entitled to assume, particularly in view of the enormous consequences of a shift to nonmember status, that the dispute would ultimately be settled retroactively—as it had always been before.

the hospitals were negotiating for a change in the cost formula which might increase the $120 per diem cost to perhaps $125, but they had no expectation that they would receive precisely their retail charge ($150) or anything close to it. Thus, on August 1, 1974, immediately prior to the signing of Act No. 94, no hospital administrator knew what he was going to be paid for Blue Cross subscriber admissions for the prior 11½ months.

Accordingly, appellants can not complain that the Pennsylvania legislature has impaired their "vested" rights to a specified payment level or their legitimate expectations to such effect, since appellants themselves held open the final rate of payment for Blue Cross subscriber admissions during the hiatus period which the statute seeks to correct.

The Issues Involved Herein are Virtually Mooted by the Timing of the Instant Litigation. The ability of a State to provide a "cooling off" procedure for future Blue Cross-hospital disputes, and its ability to regulate hospital charges prospectively from the date of enactment of a statutory rate regulation scheme are soundly based in the decisions of this Court. Thus, the only non-frivolous issues involved below dealt with the regulation of hospital charges applicable to Blue Cross subscribers for the August 15, 1974-August 2, 1975 locked-in period.

Under the terms of the payment documentation for reimbursement of the DVHC-represented hospitals during this period, virtually all of appellants' money

claims for the locked-in period have now been settled by accord and satisfaction between the parties, thus mooting this issue.[17]

B. LEGAL ANALYSIS

The Pennsylvania legislature acted reasonably and therefore constitutionally in utilizing the restoration of the Blue Cross-hospital contract as the technique for temporarily resolving the hiatus in hospitalization regulation caused by the unexpected refusal of the DVHC-represented hospitals to enter into new Blue Cross-hospital contracts subject to Pennsylvania Insurance Department regulatory review. Appellants' arguments to the contrary do not raise substantial constitutional issues.

The Power of the General Assembly to Adopt the Statutory Reimbursement Formula is Clear. It is obvious that the rates that may be collected by providers of health care services are sufficiently affected with a public interest to be amenable to regulation under the police power of the State. *Nebbia* v. *New York,* 291 U.S. 502 (1934) (rates for milk sales); *Munn* v. *Illinois,* 94 U.S. 113 (1877) (rates for grain elevators).

Indeed, legislatures have particularly broad discretion in framing solutions in the area of public health care. Thus, in the three cases in this area of which we are aware brought before this Court on

[17] A copy of the payment documentation (Ex. C to Amended Complaint) is annexed as Exhibit C hereto, *infra* page 54.

direct review in the past five years, decisions upholding the legislative judgment have been summarily affirmed:

> (1) *Clemons* v. *United States,* No. 75-348 (Salary equivalency provisions of amendment to Social Security Act establishing maximum amounts to be paid to providers of physical therapy services furnished under arrangements with provider and implementing regulations do not deprive physical therapists of equal treatment under law; legislation is good faith attempt to limit costs to reasonable fees for physical therapy services). 46 L. Ed. 2d 381 (1975).
>
> (2) *Rastetter* v. *Weinberger,* No. 74-402 (Congress may validily exclude chiropractors and naturopaths from Part B of Medicare coverage). 419 U.S. 1098 (1975).
>
> (3) *Association of American Physicians and Surgeons* v. *Mathews,* No. 75-361 (Professional Standards Review Law with respect to Medicare and Medicaid is constitutional). 46 L. Ed. 2d 299 (1975).

The only other case in this area of which we are aware brought before this Court on direct appeal had the appeal dismissed for want of a substantial Federal question. That case bears striking similarities to the case at bar:

> (4) *Murphy Nursing Home, Inc.* v. *Rate Setting Commission,* 305 N.E.2d 837 (Mass. 1973)

(Massachusetts formulae, ceilings and limitations on rates of reimbursement to nursing homes are valid, as is rate freeze on reimbursement to skilled nursing homes but not hospitals or unskilled nursing homes), *appeal dismissed,* 417 U.S. 962 (1974).

Similarly, certiorari has been denied in all recent cases in this area of which we are aware brought before this Court within its discretionary jurisdiction:

(5) *Travelers Ins. Co.* v. *Blue Cross of Western Pa.,* 481 F.2d 80 (3rd Cir. 1973) (Pennsylvania's regulation of Blue Cross-hospital contracts is not unconstitutional as to commercial insurers), *cert. denied,* 414 U.S. 1093 (1974).

(6) *New Jersey Chapter Incorporated of the American Physical Therapy Association, Inc.* v. *Prudential Life Ins. Co.,* 502 F.2d 500 (D.C. Cir. 1974) (salary-equivalency standards issued by Medicare fiscal intermediary for determining reasonable cost of services performed by independent physical therapists were proper), *cert. denied,* 420 U.S. 1004 (1975).

Finally, every decision of which we are aware not brought before this Court has sustained the constitutionality of the Blue Cross system:

(7) *New Jersey Association of Independent Insurance Agents* v. *Hopsital Service Plan of New Jersey,* 343 A.2d 739, 68 N.J. 213 (1975) (New Jersey Blue Cross arrangements are not unconstitutional as to commercial insurers).

(8) *Borland* v. *Bayone Hospital,* 300 A.2d 584, 122 N.J. Super. 387 (Ch. Div. 1973), *aff'd,* 344 A.2d 331, 136 N.J. Super. 60 (1975) (New Jersey Blue Cross arrangements are not unconstitutional as to non-Blue Cross subscribers).

The Power of the General Assembly to Make the Reimbursement Rate Partly Provisional is Clear. In establishing the reimbursement formula under Act No. 94, the General Assembly had three choices: the rate could be made provisional in whole (*i.e.,* subject to subsequent readjustment in any event), provisional in part (*e.g.,* subject to readjustment in the event of subsequent voluntary agreement on rates between the parties), or final (*i.e.,* not subject to any subsequent readjustment).

When it imposed a rate freeze on Medicaid payments to skilled nursing homes, Massachusetts opted for fully provisional rates (see *Murphy Nursing Home,* supra). Pennsylvania, on the other hand, imposed partly provisional rates by Act No. 94. Although appellants might have been better off with fully provisional rates than with partly provisional rates, there is no constitutional requirement that rates be provisional to any extent whatsoever.

In sustaining the constitutionality of the Taft-Hartley Act of 1947, this Court recognized the validity of legislation requiring that contractual arrangements be "continued for a time while further efforts [are]

made to settle the dispute." *Steelworkers* v. *United States,* 361 U.S. 39, 41 (1959).[18]

Similarly, prior to enactment of the Railway Labor Act, in sustaining the constitutionality of the Adamson Law of 1916, this Court held that the legislative power "extend[s] to doing that which was essential to prevent operation [of the railroads] from being completely stopped by filling the interregnum created by an absence of a conventional standard of wages because of a dispute on that subject between the employers and employees by a legislative standard binding on employers and employees for such a time as might be deemed by the legislature reasonably adequate to enable normal conditions to come about as the result of agreements as to wages between the parties." *Wilson* v. *New,* 243 U.S. 332, 351 (1917).

[18] Indeed, a recent amendment to the Taft-Hartley Act provides that if a labor dispute affecting a health care institution (defined to include nonprofit hospitals such as appellants) would substantially interrupt the delivery of health care in the locality concerned, a board of inquiry may be established and "[there]after . . . and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time of the impasse in the case of an initial bargaining negotiation, except by agreement, shall be made by the parties to the controversy." 29 U.S.C. § 183 (c), as added by Public Law 93-360, 88 Stat. 396. The maximum cooling off period under 29 U.S.C. § 183 is 30 days; under 29 U.S.C. §§ 178-180 the maximum period is 80 days. In view of the presumably greater resources of hospitals as compared with individual wage earners, and the virtually permanent relationship between Blue Cross and its member hospitals, the approximately one year cooling off period selected by the Pennsylvania General Assembly was obviously within the ambit of legislative discretion.

Thus, final rates could lawfully have been imposed on the hospitals, and the fact that the General Assembly was *more* solicitous of the hospitals can not defeat the validity of Act No. 94.

The Power of the General Assembly to Apply the Formula to the Hiatus Period is Clear. There is no constitutional impediment to applying the Act No. 94 formula to the 11½ month August 15, 1974-August 1, 1975 locked-in period.

"The Fourteenth Amendment does not make an act of state legislation void merely because it has some retrospective operation." *Chase Securities Corp.* v. *Donaldson,* 325 U.S. 304, 315 (1945). Rather, the constitutionality of a retrospective statute depends upon a balancing of three major factors: the nature and strength of the public interest served by the statute, the extent to which the statute modifies or abrogates preenactment rights, and the nature of the rights which the statute alters. C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692 (1960).

In the instant case, the public interest was great, the modification of rights was modest[19], and the "rights"

[19] As noted above, the statute is limited in time (i.e., to 11½ months), coverage (*i.e.,* to hospitals having benefited substantially continuously for at least 10 years from the system of guaranteed payments policed by the Commonwealth), extent (*i.e.,* most costs are reimbursed, with only free care and other disputed items omitted in reliance on the American Hospital Association-based Medicare formula), effect (any settlement reached by the parties is made effective as of August 15, 1974), and scope (most disputed claims having been settled by accord and satisfaction).

that appellants claim were altered were mere hopes or negotiating positions and not legitimate expectations.[20]

Moreover, Act No. 94 is also clearly justified as a measure to fill an unexpected gap in a rate regulatory system. *Fleming* v. *Rhodes,* 331 U.S. 100 (1947) (legislation may be made effective as of a date prior to enactment in order to fill a gap in a regulatory system); Hochman, *supra,* at 719.

Indeed, this Court has made clear that even when the Contract Clause is implicated, there is room for a legislative balancing of public and private interests which will not be disturbed by the courts. *El Paso* v. *Simmons,* 379 U.S. 497 (1965) (Texas land law).

All of Appellant's Arguments are Legal in Nature. Appellants now assert that, even if their motion below for summary judgment was properly denied, nevertheless it was improper to have granted appellees' motion below for summary judgment. At a minimum, they now allege, the lower court should have required a trial of disputed issues of fact.

Appellants cite case authority for the proposition that cross-motions for summary judgment do not *require* the court to grant one or the other. This is true, but irrelevant. There is no occasion for remand of the instant case. No facts are in dispute. The only dispute revolves around the legal effect (*i.e.,* the constitution-

[20] As noted above, the terms of final settlement for admissions to appellant hospitals for the 11½ month hiatus period have been held open by appellants themselves, so that they can not reasonably claim to be "vested" beyond the regulatory power of the Commonwealth of Pennsylvania.

ality) of a partly provisional rate formula that does not include reimbursement to hospitals for free care and other desired elements,[21] and of the application of such formula to the locked-in period.

The dissenting judge below brought this remand issue to the attention of the district court, as appellants note in their Jurisdictional Statements. A factual inquiry into confiscatory effect conceivably could be appropriate if (as the dissenting judge thought) Act No. 94 set a fixed price unresponsive to inflationary pressures. However, quite to the contrary, the statute is open-ended and automatically adjusts for inflation. And this fact is not disputed by appellants.[22]

Thus, as Circuit Judge Van Dusen and District Judge Weiner recognized in their opinion below, "Since the facts are not in dispute, there remain solely questions of law," and their grant of summary judgment for appellees was clearly correct.

[21] See note 7, *supra* at p. 12.

[22] The terms of the applicable Blue Cross-hospital contract as last amended provide for "full allowable costs with no ceiling upon a final accounting." Jurisdictional Statement in No. 75-1698, p. 8.

CONCLUSION

For the reasons set forth above, "it is manifest that the questions on which the decision of the cause depends are so unsubstantial as not to need further argument" [Supreme Court Rule 16(1)(c)], and the decision of the district court should be summarily affirmed.

Respectfully submitted,

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June 23, 1976

Exhibit A

IN THE

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

FRANKFORD HOSPITAL

v.

BLUE CROSS OF GREATER PHILADELPHIA

CIVIL ACTION

No. 74-2281

MEMORANDUM AND ORDER

NEWCOMER, J. June 8, 1976

This suit grows out of a controversy about the criteria for reimbursing hospitals for services rendered to Blue Cross subscribers. Frankford Hospital, individually, seeks damages and injunctive relief against Blue Cross of Greater Philadelphia on the ground that it has violated the federal antitrust laws.[1] On September 25, 1975, this court certified plaintiff the representative—for the purpose of injunctive relief only—of a class consisting of all Pennsylvania non-profit hospitals, clinics, and medical centers that have had a hospital contract with defendant in force at any time during the period September 4, 1970 to September 4, 1974. Extensive discovery followed. At its completion defendant filed a motion for summary judgment. For the reasons stated below this motion will be granted.

[1] Sherman Act §§ 1 and 2, 15 U.S.C. §§ 1 and 2. Plaintiff also alleges a pendent claim under Pennsylvania common law doctrines outlawing certain restraints of trade.

FACTS NOT IN DISPUTE

Defendant, Blue Cross of Greater Philadelphia, (hereinafter Blue Cross) is a nonprofit corporation which operates hospital plans whereby its subscribers are provided hospitalization and related health services. Defendant is certified to do business in the Commonwealth by the Pennsylvania Insurance Department.[2] Defendant, a member of the Blue Cross Association, headquartered in Chicago, Illinois, is the oldest of five Blue Cross plans in Pennsylvania, and has approximately 2,400,000 subscribers in the Philadelphia area.

Blue Cross is not an insurer in the classic sense of that term. In its contracts with subscribers it agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g. by employers). In order to cary out these obligations Blue Cross contracts with eligible hospitals.[3] In a typical situtation, a subscriber goes to a member hospital,[4] presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a

[2] At all times material to this action, Blue Cross existed and operated pursuant to the Nonprofit Hospital Plan Act, Act of June 21, 1937, P.L. 1948, § 1 *et seq.*, 40 P.S. § 1401 *et seq.*, as amended by the Act of November 15, 1972, P.L. 1063, No. 271, § 6101 *et seq.*, 40 Pa.C.S.A. § 6101 *et seq.* Certification of nonprofit hospital plans is provided for in 40 Pa.C.S.A. § 6102.

[3] As defined in 40 Pa.C.S.A. § 6121.

[4] Member hospitals are those which have contracts with Blue Cross.

patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in an amount determined by his particular policy.

Some of Blue Cross' subscriber agreements include indemnification provisions together with service benefit provisions. The indemnity clause comes into play when a subscriber receives care from a nonmember hospital. Under most plans, Blue Cross' obligation is a relatively small fraction of the total charge for the service. For example, a subscriber may collect fifty dollars for the first day of hospitalization and twenty-five dollars for each subsequent day while the hospital's charge exceeds two hundred dollars per day. Blue Cross' role as an indemnity insurer of health care bills is relatively modest, compared to its service benefits business. Apparently, Blue Cross could—as a legal, if not a practical matter—refuse to underwrite any indemnity agreements.

Both the rates Blue Cross charges to subscribers and its rates of payments to hospitals must be approved in advance by the Insurance Department before they can go into effect. 40 Pa.C.S.A. § 6124. At all times material to this action, the Pennsylvania Insurance Department has aggressively regulated Blue Cross' contractual relationships with subscribers and with hospitals. Prior to 1967, there were at least six different agreements between Blue Cross and various hospitals in the Philadelphia area. The Department instructed Blue Cross to develop a uniform contract. It

particularly stressed that this contract should include the cost accounting principles upon which reimbursement under the federal Medicare Program was based. At the end of 1967, defendant submitted a proposed uniform cost contract between Blue Cross and Philadelphia area hospitals. The Insurance Commissioner, David O. Maxwell, disapproved it. In his notice of disapproval the Commissioner stated, *inter alia,* that Blue Cross should neither have to pay any portion of the hospitals' unreimbursed outpatient cost, nor to pay for depreciation or for miscellaneous unidentified costs under formulas which did not include specific incentives to hospitals to control costs.[5] Mr.

[5] "Section 1-11 of Exhibit A provides for the allowance of certain unreimbursed outpatient costs. [This results from the rendering of services to persons who are not Blue Cross subscribers and who do not fully pay their hospital bills.] The basis of payment is, generally the ratio of Blue Cross inpatient days to total inpatient days times outpatient costs for which the hospital has not been reimbursed from any source. Blue Cross would of course continue to pay for outpatient costs incurred by its subscribers."

". . . It can therefore truthfully be described as an involuntary contribution by Blue Cross subscribers to the maintenance of emergency and clinical outpatient services."

• • •

"In my opinion, the maintenance of these essential facilities is a community responsibility, including federal, state and local governments as well as eleemosynary institutions and the public. It is not fair to shift that part of the burden which the community is neglecting to bear to Blue Cross subscribers without their consent and in accordance with a method of calculation largely unrelated to the cost to the hospital of proving outpatient services." Letter to Mr. Thomas F. Manley, President, Blue Cross of Greater Philadelphia, from Insurance Commissioner, David Maxwell (undated), Exhibit E to Affidavit of Bruce Taylor, President, Blue Cross of Greater Philadelphia, pp. 8-9.

Maxwell's successors—Commissioners George F. Reed, Herbert S. Denenberg, and William J. Sheppard—adhered to the position that any contract between Blue Cross and Philadelphia area hospitals must include quality controls and ceilings on total cost reimbursement.[6]

After Commissioner Maxwell's rejection of the 1967 proposed Uniform Cost Contract, Blue Cross resumed negotiations with the hospitals and a new agreement[7] was reached by them and subsequently approved by the Commissioner. In 1971, Blue Cross resubmitted to the Pennsylvania Insurance Department for its approval a request for increases in rates charged to subscribers. Commissioner Denenberg's denial of the request sparked new, intensive negotiations between Blue Cross and the hospitals (which were represented

[6] In a letter to Blue Cross dated November 6, 1973, Insurance Commissioner Denenberg made the following comments about "free care":

"This department cannot and will not approve the submitted cost-plus factor. I draw your attention to several basic reasons. First, free care, the alleged cause of the plus factor, is not a cost connected with Blue Cross coverage . . . Blue Cross cannot pay for services outside of Blue Cross coverage.

In short, Blue Cross, itself a nonprofit corporation is not authorized to make contributions or gifts to hospitals in recognition of free services which may have been provided to the community. . . ."

• • •

"Sixth, the provisions and financing of free care service is a community problem. Costs of free care should be shared by the entire community through appropriations from government funds or otherwise." Exhibit M to Affidavit of Bruce Taylor, pp. 1-3.

[7] Uniform Cost Contract—1967.

in the negotiations by the Delaware Valley Hospital Counsel, hereinafter DVHC). The Commissioner attended many of the negotiating sessions. These efforts resulted in the Hospital Agreement of 1971, the terms of which reflected Commissioner Denenberg's negotiating guidelines.

Negotiations to reach agreement on a contract to succeed the 1971 Agreement commenced in March 1973. The negotiations, however, were not very successful, and before they were completed the 1971 Agreement expired. At this juncture the hospital split ranks. In September, 1974, a number of the DVHC-represented hospitals became non-member hospitals. A number of other DVHC-represented hospitals, including the Philadelphia medical school hospitals, agreed with Blue Cross to extend the terms of the 1971 Agreement during the pendency of negotiations. In November, 1974, a number of Philadelphia hospitals reached agreement with Blue Cross on a contract. The Insurance Department approved it. This "1974 Agreement," which was retroactive to July 1, 1974, has been adhered to by all Philadelphia medical school hospitals (including one which did not actually sign it) and has been signed by some DVHC-represented hospitals and a number of community hospitals. Approximately 40 DVHC-represented hospitals refused to sign it.

The situation in which a large number of Philadelphia area health care facilities were not Blue Cross member hospitals created extreme problems for some

subscribers in need of treatment. Both Blue Cross and the DVHC took out advertisements in newspapers at various times to inform the public about which hospitals were and were not under contract with Blue Cross to provide subscriber services. Some Blue Cross subscribers sought services in non-member hospitals either by mistake or because of the exigencies of medical emergencies, or for other reasons. It was an unhappy surprise to many when they learned that they were personally liable for substantial bills. On August 2, 1975, the Commonwealth of Pennsylvania enacted Act No. 94 of 1975, (40 P.S. § 6124c). It reinstated, retroactively, the 1971 Hospital Agreement between Blue Cross and the non-member DVHC hospitals.[8] Under Act 94, the Blue Cross-hospital contracts may be terminated only after notice is first given to the Insurance Department which then can initiate various procedures during a "cooling off" period. Thirty-one hospitals sent notice to the Commissioner on and after August 25, 1975. In a decision rendered on May 21, 1976, Commissioner Sheppard ruled that he would not approve termination of the contractual relationship. At the same time, he set forth findings—which are comparable to guidelines—on the two remaining dis-

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[8] The constitutionality of this act was upheld by a three-judge court in Guest *v.* Fitzpatrick, Civil Action No. 75-2306 (E.D. Pa. Feb. 27, 1976), *appeal pending*. Judge Luongo dissented from the majority opinion of Judge Weiner and Circuit Judge Van Dusen.

puted areas in the negotiations. Clearly, state regulation of Blue Cross hospital contracts is still vigorous.[9]

Frankford Hospital contends that the 1967 and 1971 Agreements were unreasonable because under them Blue Cross paid for less than its proper share of the operating cost attributable to the treatment of Blue Cross subscribers. It claims that Blue Cross used its position of power and dominance to coerce the hospitals into signing the agreements. The "discount" on hospital services Blue Cross achieved under the contracts, as compared to what non-subscribers and their private insurers had to pay, was allegedly exploited to Blue Cross' advantage in further consolidating a monopoly in the health insurance market. Frankford Hospital asks the court to find that the 1971 Agreement is illegal, and to order defendant Blue Cross to offer to enter into a superceding agreement with members of the plaintiff class. Under the court-ordered contract Blue Cross would pay a pro-

[9] Commissioner Sheppard ordered that the termination of the contracts be suspended for ninety days. He observed that

> "the parties should be able to conclude [the negotiations] successfully within the very near future. . . ." Defendant Exhibit V, p. 3.

It would appear that Commissioner Sheppard, unlike some of his predecessors, is willing to approve a hospital contract under which Blue Cross bears some share of free care and bad debt costs. He stated:

> "[I]t is appropriate and proper for Blue Cross, on behalf of its subscribers, to bear an appropriate portion of certain free care and bad debt costs of member hospitals, after crediting against such free care and bad debt costs the resources available to hospitals for such purposes from sources other than patient payments." p. 2.

rated share of all operating costs, which included bad debts, free care, and "working capital requirements." Thus, although the plaintiff's theory of liability relates to events occurring in the four years prior to September 4, 1974, its prayer for relief rests on the assumption that federal antitrust law preempts the Commonwealth's Act 94, and this court is therefore obligated to declare unreasonable and unlawful the very contract which the legislature recently reinstated. Blue Cross' principal defense is that the McCarran-Ferguson Act expressly exempts from the federal antitrust laws the activities of which the plaintiff complains. It argues that federal law has, by its own terms, reserved these areas in the first instance for state regulation. Because our decision is firmly grounded on the McCarran-Ferguson Act, we do not discuss Blue Cross' defense based on *Parker* v. *Brown*, 317 U.S. 341 (1943).

McCARRAN-FERGUSON ACTS

Frankford Hospital has charged Blue Cross with restraining trade, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1,[10] and with monopolizing and attempting to monopolize, in violation of Section 2 of that Act.[11] Blue Cross contends that it has not

[10] "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states . . . is declared to be illegal. . . ."

[11] "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states . . . shall be deemed guilty of a misdemeanor. . ."

violated the precepts contained in these Sherman Act provisions and, in any case, these rules themselves are inapplicable to the actions herein challenged by the language of the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* Section 1012(b) provides in pertinent part:

> ". . . The Sherman Act . . . shall be applicable to the *business of insurance* to the extent that such business is not *regulated* by State Law." (emphasis supplied)

Excluded from the protection of this exemption are certain practices, namely—boycott, coercion or intimidation. Section 1013(b) of 15 U.S.C. provides:

> "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce or intimidate, or any act of boycott, coercion, or intimidation."

Substantially similar arguments to those advanced by plaintiff in this case were adjudicated in *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania,* 361 F. Supp. 774 (W.D. Pa. 1972), aff'd 481 F.2d 80 (3d Cir.) *cert. denied* 414 U.S. 1083 (1973). After a lengthy trial the district court dismissed plaintiff's complaint on the alternative grounds (a) that the defendant could avail itself of the McCarran-Ferguson Act exemption because its contracts with hospitals were part of the business of insurance; these contracts were aggressively regulated by the Commonwealth of Pennsylvania; and the defendant

had not, in connection with these contracts, accompished an unreasonable restraint of trade through boycott, coercion, or intimidation as those terms are defined in 15 U.S.C. § 1013(b); and (b) assuming that the McCarran-Ferguson Act exemption did not apply, Blue Cross of Western Pennsylvania did not engage in any unlawful monopolization or restraint of trade. The Third Circuit affirmed on each of these grounds.

It is unnesssary to pass beyond the McCarran-Ferguson Act issue in order to decide the present motion. *Travelers* held that the rates Blue Cross of Western Pennsylvania charged its subscribers were so interrelated with the terms of Blue Cross' hospital contracts that the latter should be considered part of the business of insurance. 481 F.2d at 83. That conclusion was based on facts which were alike in all material respects to the undisputed facts in this case. Moreover, the argument that *Travelers* should be distinguished from the instant case either because it involved a different Blue Cross plan and a different set of negotiations, or because a suit brought by a private insurance carrier presented the questions in a different light than suit brought by a class of hospitals, was destroyed by the recent affirmance of *Doctors Hospital* v. *Blue Cross of Greater Philadelphia,* Civil Action No. 73-1057 (E.D. Pa. Aug. 13, 1975), *aff'd per curiam* No. 75-2166 (3d Cir. April 28, 1976). This narrows our task to making a determination whether there is any triable issue of material fact with respect to Frankford Hospital's assertions that

Blue Cross of Greater Philadelphia has carried out acts of boycott, coercion or intimidation prohibited by 15 U.S.C. § 1013(b).[12]

All doubts as to the existence of a genuine issue as to a material fact must be resolved against the party moving for summary judgment. *Lockhart* v. *Hoenstine,* 411 F.2d 455 (3d Cir. 1969), *cert. denied* 396 U.S. 941 (1970). At the same time, general allegations which do not show facts in detail and with precision are insufficient to prevent the award of summary judgment. *Tunnell* v. *Wiley,* 514 F.2d 971, 976 (3d Cir. 1975), *Engl* v. *Aetna Life Insurance Co.,* 139 F.2d 469, 473 (2d Cir. 1973). A party who resists summary judgment cannot hold back his evidence until the time of trial, *Robin Construction Co.* v. *United States,* 345 F.2d 610, 613 (3d Cir. 1965), and this is particularly true when the party has taken extensive discovery and has been given every reasonable opportunity to build a record and to draw the court's attention to favorable selections from it.[13]

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[12] Because we conclude that § 1013(b) is inapplicable, it is unnecessary for us to decide whether Blue Cross would be entitled to summary judgment on the ground that its activities in the Philadelphia area did not constitute unlawful monopolization or restraint of trade.

[13] After oral argument on this motion the court granted the defendant's motion to strike plaintiff's affidavits on the ground that they failed to conform to the requirements of Rule 56(e). Plaintiff was given leave to submit additional affidavits and to file a supplemental brief pointing out pertinent portions of deposition testimony. Order of May 20, 1976.

We find that no material facts are in dispute. The crux of this case is not what Blue Cross has done, but how its actions should be characterized, in the context of section 1013(b). Some hospital administrators have repeatedly asserted that Blue Cross has coerced their institutions to try to force them to sign contracts. Some hospitals have succumbed to the alleged coercion; others have not. Blue Cross does not deny that a hospital which changes from member to non-member status suffers adverse financial consequences, nor that the administrators of a hospital operating under either the 1971 or 1974 Agreement might believe that Blue Cross is not assuming a fair share of hospital costs. But defendant insists that nothing it is doing is coercion. To the contrary, it says it is doing the business that the legislature has intended it to do. In fact, some of the contractual provisions objected to by the plaintiff have been more or less frozen into Blue Cross' negotiating position by the decisions of the Insurance Department.

The terms, "boycott, coercion, or intimidation," must be interpreted with attention to the structure of the statutory provisions to which they are related. The Sherman Act proscribes practices which are monopolistic or are otherwise unreasonable restraints of trade. The McCarran-Ferguson Act creates an exemption from the Sherman Act provisions, but at the same time allows for an exception to the exemption. In this context, the terms, boycott, coercion, and intimidation, cannot be given as broad a meaning as they might have if used to define unreasonable re-

straint of trade. Otherwise, the Section 1013(b) exception would all but swallow up the body of the McCarran-Ferguson exemption. The exception must have been aimed at particular known practices in the insurance industry which Congress intended to outlaw irregardless of any efforts undertaken by the state to eliminate them through regulation. In *Meicler* v. *Aetna Casualty and Surety Co.*, 372 F. Supp. 509 (S.D. Texas 1974) *aff'd* 506 F.2d 732 (5th Cir. 1975), the district court stated:

> "It cannot be disputed that the terms boycott and coercion, as commonly defined, might be construed to encompass the type of activity attributed to defendants in the instant case. An examination of the legislative history of this section reveals, however, that Congress was seeking to regulate a rather narrow area of activity bearing no resemblance to the situation described in Plaintiffs' Complaint. Section 1013(b) was designed *primarily* to deal with conspiracies or combinations among insurance companies and agents for the purpose of boycotting or refusing to deal with other insurance companies and agents." (emphasis supplied) 372 F. Supp. at 513-514.[14]

[14] We apply emphasis to the word "primarily" because we do not believe section 1013(b) should be strictly limited to the classic situation of insurance company blacklisting. In appropriate circumstances, the language of that provision would reach other practices which have the same purpose and effect as blacklisting or which are equally pernicious in violating the most fundamental notions of competition and fair play. In the instant case we are not presented with circumstances that require us to decide this issue. *But see* Addrisi *v.* Equitable Life Insurance Society, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 947 (1975).

Frankford Hospital's reliance on *Battle* v. *Liberty Life Insurance Company*, 493 F. 2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975), is misplaced. In that case the plaintiff was challenging activities of an insurance company (involving an arrangement with an additional party) that had *nothing to do with the issuing of insurance*. The court held that the McCarran-Ferguson Act exemption did not apply to the instant complaint. It explicitly distinguished *Travelers Insurance Company* v. *Blue Cross, supra*. In *dictum*, the court stated that even if the McCarran-Ferguson Act applied, the complaint would survive a motion to dismiss, because of allegations that brought Section 1013(b) into play. The complaint alleged, *inter alia*, that the defendants threatened to build funeral homes to compete with the plaintiffs' businesses; threatened physical violence against the plaintiffs and their agents; and threatened to cancel insurance contracts. Frankford Hospital has not alleged threats of physical violence, or threats to build competing hospitals, by Blue Cross. Furthermore, it is undisputed that Blue Cross as not threatened to cancel any contracts but rather has continuously offered to enter into the 1971 and 1974 uniform cost contracts with plaintiffs.[15]

[15] We note, however, that Frankford Hospital contends that Blue Cross has used its existing contractual relationships with the hospitals by intentionally withholding large sums of money which it owes to the hospitals in order to coerce them into signing a new contract.

Frankford Hospital asserts that the provisions in Blue Cross subscriber contracts which set the rates of reimbursement for services received from non-member hospitals are "coercive." The district and the circuit court considered virtually the identical argument in *Travelers, supra,* and reached the conclusion:

> "[T]he economic inducements which made the Blue Cross contract acceptable to hospitals did not amount to 'coercion'." (footnote omitted) 481 F. 2d at 84.[16]

In *Doctors Hospital* v. *Blue Cross of Greater Philadelphia, supra,* the court rejected the plaintiff's claim that Blue Cross committed an act of boycott, coercion or intimidation by placing an advertisement in a newspaper which informed the public of the date at which Doctors Hospital would no longer be a Blue Cross member hospital. After certain DVHC hospitals became non-member hospitals on or about September 1, 1974, Blue Cross took steps to notify its subscribers of the names of those hospitals which were continuing to provide member benefits to all subscribers. These steps included the running of newspaper notices. Copies of these advertisements are in the record.[17] None of them is any more coercive to non-member

[16] The omitted footnote in the above quoted passage stated, "If a hospital refused to agree to the contract, Blue Cross would reimburse the hospital on a per diem basis at an amount insufficient to cover the hospital's costs. A hospital would have to make up any deficiency by charging the patients directly. We note that this procedure is typical of the indemnification plans offered by private insurance companies."

[17] Exhibit P, Q and U to Affidavit of Bruce Taylor.

hospitals than the inoffensive advertisement considered in *Doctors Hospital.* Even without this precedent, we would have to conclude that these notices were not only non-coercive within the meaning of section 1013(b) but that it was a responsible business decision to communicate to subscribers the information contained therein.

We will now discuss the allegations of plaintiff which do not have direct corollaries in *Travelers* and *Doctors Hospital.* First, we consider plaintiff's attempt to give a factual basis to its boycott theory. Assuming *arguendo,* that the term, boycott, in section 1013(b) extends to boycotts of persons other than insurance companies and insurance agents,[18] Frankford Hospital still has not created a triable issue of material fact as to its allegation that Blue Cross has conspired with others or otherwise conducted a boycott of non-member hospitals. Frankford Hospital contends that the defendant's main boycott device is its subscriber contracts, which provide that subscribers who are treated in non-member hospitals receive indemnity from Blue Cross in amounts less than the full charges for those services. The argument is that the differential diverts Blue Cross subscribers away from member hospitals and therefore by contracting with hospitals for services Blue Cross is boycotting all hospitals with which it does not contract. Plaintiff also alleges that the defendant has fueled the boycott by running newspaper advertisements that urge sub-

[18] *But see,* Meicler, *supra,* and Addrisi, *supra.*

scribers (and, incidently, the general public) to stay away from non-member hospitals, and by conspiring with union officials to exort union member subscribers from patronizing non-member hospitals. As discussed above *Travelers and Doctors Hospital* have disposed of any notion that the terms of Blue Cross indemnity agreements in subscriber contracts and/or newspaper advertisements which Blue Cross has run constitute prohibited boycotts. As to the allegation of a Blue Cross-union conspiracy, Frankford Hospital has to rest much of its argument on a leaflet issued by Local 834 of the United Auto Workers which stated, *inter alia,*

> "[A]gain, we ask you, if at all possible please stay out of the non-participating hospitals."

There is no evidence that Blue Cross either had prior knowledge that this statement would be made or that it encouraged or counseled the making of such a statement. The uncontradicted depositions of Francis J. McGuire, President, United Automobile Workers Local No. 834, and of Cecil V. Mullen, President, International Brotherhood of Electrical Workers Local Union No. 1241, make clear that the leaders of these locals acted at their own initiative to try to protect their members from suffering unexpected financial hardships as a result of going to non-member hospitals. They sought information from Blue Cross in order to advise their members; Blue Cross repesentatives gave them basic information about coverage under the particular union contracts. On one occasion, a Blue

Cross representative said that a subscriber who is treated in a non-member hospital could anticipate being asked to pay his or her bill before checking out. Mr. Mullen volunteered the information that a protest letter he wrote to non-member hospitals contained mistaken assertions. He had made some hasty conclusions based on what he was told by the Blue Cross representative, and based on unreliable information from other sources.[19] Similarly, the comments Mr. McGuire addressed to union members (and are objected to by Frankford Hospital) were based on his own ideas and information.[20]

In conclusion, each of the alleged elements of the "boycott" lacks a factual or a legal basis, if not both.

Second, Frankford Hospital alleges that Blue Cross has failed to negotiate with the hospitals in good faith. We fail to see how this allegation, even if true, would

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[19] The following exchange in the Mullen deposition illustrates the small role played by Blue Cross representatives:

> "By Mr. Bogus [plaintiff's counsel]: Mr. Mullen, did you have occasion to discuss this matter with any one else at Blue Cross other than Mr. Gannon?
>
> Mr. Mullen: No, I have a very hard time getting anyone at Blue Cross to talk to me." Deposition p. 14.

[20] "Mr. Bogus: Did anyone at Blue Cross tell you that non-participating hospitals were likely to harrass or pester your members? [Objected to by Blue Cross counsel]

Mr. McGuire: No. The hospitals have did it, though. The hospitals have did it. They have harrassed and pestered our members.
Q: Have you discussed that problem with anyone at Blue Cross?
A: To the point where, you know what's happening, has there been anything done through negotiations or stuff like that." McGuire Deposition p. 9.

activate section 1013(b). Even if we assume that Blue Cross has been able to adhere to unreasonable negotiating positions because of its dominance in the health insurance market, that would take the plaintiff no further than stating an element of a cause of action under the Sherman Act. But the Sherman Act is irrelevant until plaintiff can carry its burden of showing that the McCarran-Ferguson Act does not apply, and the allegation of bad faith negotiations does not prove that point. In any event, we do not think the plaintiff has established a triable question of fact on the good faith of Blue Cross negotiations in the face of the approval by the Insurance Department of the 1971 and 1974 agreements, and in the face of the Commonwealth's enactment of Act 94. Moreover, the participation of the insurance department in the negotiation of hospital contracts is unabated and so long as this active regulation continues it is the province of the commissioner to rule on the good faith or bad faith of the negotiating parties.[21]

There are some remaining allegations of coercion. Plaintiff says Blue Cross has withheld information from non-member hospitals about the benefits that Blue Cross subscriber patients are entitled to; that Blue Cross has refused to honor assignments of benefit agreements which would entitle non-member hospitals to be paid directly by Blue Cross; that Blue Cross has refused to adjust interim rates of reimbursements to hospitals, as required by existing contract;

[21] See *supra*, at p. 7, [pagination in manuscript opinion]

and that Blue Cross has otherwise "systematically ignored and abused clear legal rights of the hospitals." At least two of these alleged actions are the subject matter of state court contract actions and a third has resulted in a settlement. Even if these grievances could support causes of action under state law, and even if they might be unreasonable restraints of trade if that question were ever reached under section 1 and 2 of the Sherman Act, they do not have any bearing on the McCarran-Ferguson Act exception, 15 U.S.C. § 1013(b).

We conclude that judgment must be entered for the defendant on the antitrust claims alleged in the complaint. The subject of this action is the business of insurance and it is being aggressively regulated by the Commonwealth of Pennsylvania. The plaintiff has failed to make a preliminary factual showing that it might, at trial, prove that this case comes under the exception to the McCarran-Ferguson Act's general exemption of regulated insurance activities from antitrust scrutiny. Furthermore, because judgment will be entered against plaintiff on its federal claims (which conferred jurisdiction on this court) prior to trial, we decline to exercise pendent jurisdiction over its state law claims. *United Mine Worker* v. *Gibbs,* 383 U.S. 715, 726 (1966).[22]

CLARENCE C. NEWCOMER, *J.*

[22] In declining to exercise pendent jurisdiction we have also considered that it is extremely unlikely that we would ever decide the

(footnote continued on following page)

merits of the state law claims in plaintiff's favor. Only a novel state law argument could defeat the otherwise obvious conclusion that Pennsylvania common law doctrines of unfair competition have been preempted by the statutes establishing non-profit hospital plans and providing for their regulation; and by Act 94. However, before we would base a decision on a novel state law claim we would abstain so that that decision could be made, if at all, in the state courts. Thus, had we exercised pendent jurisdiction the best result the plaintiff could have expected would have been for the court to abstain. Thus it is made no worse off by our failure to exercise pendent jurisdiction.

Exhibit B

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

July 8, 1975

Honorable William A. Shephard
Insurance Commissioner
Insurance Department
Finance Building—Room 108
Harrisburg, PA. 17120

Dear Commissioner Shephard:

At our meeting on July 3, 1975, Governor Shapp asked us to put in writing what we consider to be the remaining issues and to state our position on each of them.

DVHC believes the remaining issue are as follows:

1. *Unreimbursed Patient Care and Operating Growth Need*

We will accept annually 7½% based on the total Blue Cross reimbursable costs of Provider which shall be paid to the Delaware Valley Hospital Council and distributed by it among the Providers.

2. *Areawide Planning of Health Care Facilities*

Provider shall comply with PL 92-603 § 1122 and applicable sections of PL 93-641 when implemented.

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

We do not object to the "B" Agency, or whatever agency is empowered under the law contracting with the Hospital Survey Committee to perform functions required by law. However, only the final decisions made by the planning agency designated by law will be binding on the parties.

3. *Term of Agreement*

We will agree to a firm two (2) year contract terminating on June 30, 1977, with neither party having the right to terminate the agreement during the two (2) year period. However, we will not agree to any run-out period after June 30, 1977.

4. *Retroactivity*

We believe that any agreement has to be retroactive to July 1, 1974.

During the retroactive period Providers will be reimbursed their total Blue Cross reimbursable costs based generally on the 1971 Agreement as modified by the 1973 Agreement of Principles and recent negotiations, and with no ceilings or Medicare cost limitations of any kind.

We would agree to your suggestion to give Blue Cross credit for money paid to Subscribers where

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

Blue Cross has paid non-member benefits on a per diem basis, but if Blue Cross has paid full charges to a patient, we will not give Blue Cross credit for the amount in excess of reimbursable cost. Providers will actively pursue collection procedure against those patients who did not pay Provider the money received from Blue Cross.

We believe that we have reached agreement on the other items. However, we cannot be sure until we attempt to put the other items into contract form.

Sincerely yours,

/S/ FRANK H. ABBOTT
Frank H. Abbott, Attorney
for Delaware Valley
Hospital Council

Exhibit C

[Letterhead of Blue Cross of Greater Philadelphia]

August 20, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

Today the plaintiffs in *Guest, et al.* v. *Fitzpatrick, et al.*, Civil Action No. 75-2306, withdrew their request to have the United States District Court for the Eastern District of Pennsylvania enjoin the use by Blue Cross of the payment procedures described in my letter of August 5, 1975 (an additional copy of our letter of August 5, 1975 is enclosed for your convenience). Accordingly, since it is necessary that Blue Cross not be exposed to the obligation to make duplicate payments to the Provider and Subscriber for the same Covered Services, checks will continue to be issued with a restrictive endorsement.

However, it appears that there may be some misunderstanding concerning the purpose, scope and effect of the payment procedure adopted.

While Blue Cross will support the constitutionality of Act No. 94 in the pending litigation, there is no intention that the negotiation or transfer of Blue Cross checks will deprive any hospital payee of its

[Letterhead of Blue Cross of Greater Philadelphia]

right, should it desire to do so, to challenge the constitutionality of Act No. 94 generally or, once having cashed one or more Blue Cross checks with respect to certain admissions, to change its policy and refuse to accept and negotiate checks with respect to future or other admissions.

The purpose of the payment procedure is simply to eliminate the uncertainty produced by the attack on Act No. 94 by reaching a mutually-agreed settlement as to the payments to be made by Blue Cross and a subscriber to the Provider with respect to *only* those admissions covered by the particular check in question.

By negotiating or transferring a Blue Cross check which refers to this letter, the Provider will be agreeing that payment by Blue Cross under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") will be the only payment which the Provider will seek with respect to the particular admissions covered by the check in question, and that the Provider will not, *as to those particular admissions only,* make any direct claim against the subscriber not permitted by the Agreement.

We hope you will agree that this is a practical and responsible arrangement in light of the pending uncertainty over the status of Act No. 94.

[Letterhead of Blue Cross of Greater Philadelphia]

If, after reviewing the foregoing, you have any questions as to the payment procedures which Blue Cross intends to follow, please feel free to contact our officers.

Very truly yours,
/S/ HOWARD W. BAKER
Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure

Restrictive Endorsement

Front

"This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form."

Back

"The payee intending to be legally bound hereby agrees that by this negotiation or transfer of this instrument the payee named hereon agrees that it has accepted and will be bound by the provisions of the drawer's letter of August 6, 1975 to the payee relating to Act No. 94."

[Letterhead of Blue Cross of Greater Philadelphia]

August 21, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

Under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") which has been reinstated by Act No. 94, Blue Cross is obligated to provide your hospitals with current financing (i.e., working capital advances). We desire to reinstate these advances as soon as practical, but we are faced with the uncertainty created by the pending litigation challenging the constitutionality of Act No. 94.

In the event Act No. 94 is declared unconstitutional, it will, of course, be appropriate for such advances to be returned to Blue Cross. Since in such an event Blue Cross will not be holding amounts payable to a hospital out of which to recover the advance, and since the very existence of the advance is a recognition on the part of a hospital of the need for working capital, effective provisions for repayment of these advances raises significant practical problems.

One option would be for a hospital to give Blue Cross appropriate security for prompt repayment of

[Letterhead of Blue Cross of Greater Philadelphia]

the advances, and we stand ready to discuss these arrangements on an individual basis, recognizing that Blue Cross will need to be provided with security of a quality and availability comparable to that contemplated by the Agreement under normal termination circumstances.

Recognizing that in some situations a hospital will not be in a position to offer such security, we believe that equivalent security would exist if a Provider agrees that in the event Act No. 94 is declared unconstitutional, it will thereafter voluntarily handle sufficient new admissions under the Agreement to exhaust the amount of the advance then outstanding. This is similar to the normal termination of the Agreement and should in general be fully compatible with your existing financing arrangements and restrictions.

In order to expedite payment of the advances, they are being tendered to you on the assumption that the arrangements stated in the previous paragraph are acceptable to you, and by negotiating or transferring the check or checks representing such advances you will be deemed to have agreed to such contingent repayment arrangement.

If you prefer to make other arrangements for security which is equivalent to the security which would exist under the Agreement in a case of normal termination, you should return the enclosed check, and ad-

vise us of the nature of the security which you can make available.

Very truly yours,

/S/ HOWARD W. BAKER
Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure

[FORM OF CHECK]

This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form.

Blue Cross
of Greater Philadelphia
1833 Chestnut Street
Philadelphia, Pennsylvania 19107

3-50
310
93809

Pay: LANKENAU HOSPITAL
LANCASTER &
CITY LINE AVENUES
PHILA., PENNA. 19151

The Fidelity Bank, Philadelphia, Pa.
Hospital Service Account
Check Number 093809
AMOUNT $327,457.00
Exactly $327,457 Dollars and 00 Cents
Date 08/21/75
Void after 60 days

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

August 21, 1975

William Zeiter, Esquire
Morgan, Lewis & Bockius
123 South Broad Street
Philadelphia, PA. 19109

Re: Blue Cross letter of August 20, 1975 to
Chief Executive Officers

Dear Mr. Zeiter:

The purpose of this letter is to confirm your statement to me of today that by cashing the checks referred to in your letter, the hospitals agree not to pursue any claims against the subscribers for whom Blue Cross has made payment, and Blue Cross agrees that even if Act 94 is held to be unconstitutional Blue Cross will not claim any refund of the monies paid. Furthermore, it is understood the cashing of the checks would have no effect on retroactivity of our current negotiations.

Sincerely yours,

/S/ FRANK H. ABBOTT
Frank H. Abbott
For SCHNADER, HARRISON, SEGAL
& LEWIS

[Letterhead of
MORGAN, LEWIS & BOCKIUS
Counselors at Law
123 South Broad Street
Philadelphia, Pennsylvania 19109]

August 22, 1975

Frank H. Abbott, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Re: Blue Cross letter of August 20, 1975 to
Chief Executive Officers

Dear Mr. Abbott:

The first sentence of your letter of August 21, 1975 correctly summarizes the substance of our recent telephone conversation.

I am not clear as to the meaning of "retroactivity of our current negotiations" in the second sentence of your letter, but since I take it that it relates to a subject beyond the scope of the matters mentioned in the first sentence of your letter, you are correct that cashing of the subject checks would have no effect thereon.

With kindest regards,

Sincerely,

/S/ WILLIAM E. ZEITER
William E. Zeiter

sk
cc: David S. Markson, Esquire

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

August 27, 1975

Mr. Bruce Taylor
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, PA. 19107

Dear Bruce:

The purpose of this letter which is being sent on behalf of all the hospitals represented by the Delaware Valley Hospital Council in the current negotiations with Blue Cross is to inform you that the hospitals refuse to accept the terms and conditions set forth in Dr. Baker's letters of August 5, August 20 and August 21, 1975.

Act No. 94 makes no provisions for Blue Cross unilaterally making restrictions on the payments it makes to the hospitals. If anyone is to impose restrictions, it shall be the Court, by whose holding the hospitals will abide.

Accordingly, the hospitals refuse to accept or be bound by the restrictive endorsements on the checks being issued and the terms and conditions set forth in the letters. We have been instructed to inform you that on September 2, 1975 the hospitals will cash all

checks in their possession and if you insist that the restrictive endorsements are binding, it is up to you to stop payment on the checks before September 2, 1975.

With best regards,

Sincerely yours,

/S/ FRANK H. ABBOTT
Frank H. Abbott
For SCHNADER, HARRISON, SEGAL & LEWIS

August 27, 1975

Hospitals Represented by the Delaware Valley Hospital Council

Abington Memorial Hospital
All Saints Hospital
Booth Maternity Center
Bryn Mawr Hospital
Bryn Mawr Rehabilitation Center
Clement Atkinson Memorial Hospital
Crozer Chester Medical Center
Delaware County Memorial Hospital
Delaware Valley Hospital
Doylestown Hospital
Episcopal Hospital
Frankford Hospital
Germantown Dispensary & Hospital
Holy Redeemer Hospital
Jeanes Hospital
John F. Kennedy Memorial Hospital
Lankenau Hospital
Magee Memorial Hospital
Memorial Hospital, Roxborough
Mercy Catholic Medical Center
  Misericordia Division
  Fitzgerald Mercy Division
Methodist Hospital
Montgomery Hospital
Nazareth Hospital

Northeastern Hospital
Paoli Memorial Hospital
Phoenixville Hospital
Presbyterian-University of
  Pennsylvania Medical Center
Riddle Memorial Hospital
Sacred Heart Hospital, Chester
Sacred Heart Hospital, Norristown
Saint Christopher's Hospital for Children
Saint Joseph's Hospital
Suburban General Hospital
Taylor Hospital
West Park Hospital
Wills Eye Hospital

[Letterhead of Blue Cross of Greater Philadelphia]

August 27, 1975

Frank H. Abbott, Esq.
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Dear Frank:

This will respond to your letter of August 27, 1975 (copy attached) relating to negotiation of Blue Cross checks.

As you know from your participation in proceedings before the United States District Court for the Eastern District of Pennsylvania in *Guest et al* v. *Fitzpatrick et al,* Civil Action No. 75-2306, Blue Cross is exposed to a substantial risk of duplicate payment liability if Public Act No. 94 is held invalid.

In the absence of the Act our obligation with respect to admissions in Delaware Valley Hospital Council represented institutions is solely to pay the non-member benefit to our Subscribers. Under the Act our obligation is to pay the Provider institution.

As you also know, the District Court, when considering your attack on our payment practices, made clear that Blue Cross has every right to protect the Plan against the risk of duplicate payment in the present uncertain circumstances. As a community

[Letterhead of Blue Cross of Greater Philadelphia]

agency responsible to our subscribers and the Pennsylvania Insurance Commissioner, we cannot permit large contingent liabilities for duplicate payments to accrue. Instead we have adopted procedures which permit the establishment of a definitive payment program for Providers; one which permits Blue Cross, the Subscriber and the Provider to know immediately the economic consequences of a particular admission. In view of the indefinite time which a challenge to the validity of Public Act No. 94 will doubtless consume, and the availability throughout the community of a substantial number of member hospitals whose status is unaffected by the validity or non-validity of Act No. 94, such a clarification of the status of admissions to DVHC hospitals is clearly in the public interest.

Accordingly your counteroffer, as contained in your letter of August 27, 1975 must be, and is hereby, rejected. Any negotiation or transfer of our checks bearing reference to Dr. Baker's letters of August 5, August 20, August 21 and/or August 26, 1975 will be deemed an offer by the payee hospital to accept settlement with Blue Cross on the basis set forth in the applicable provisions of Dr. Baker's above-mentioned letters. In addition, because of the mechanical problems incidental to the administration of our Hospital Service Account, we could consider any further counteroffers on behalf of a payee hospital only when

[Letterhead of Blue Cross of Greater Philadelphia]

the counteroffer is accompanied by the return uncashed to Blue Cross of the Blue Cross check or checks to which the counteroffer relates.

Yours very truly,

/S/ BRUCE TAYLOR
Bruce Taylor
President

BT:ccb

cc: CHIEF EXECUTICE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MOTION TO DISMISS No. 75-1691 BASED UPON MOOTNESS
MOTION TO AFFIRM No. 75-1698 BASED UPON INTERVENING CIRCUMSTANCES

WILLIAM E. ZEITER
ROY K. MEILMAN
2100 The Fidelity Building
Philadelphia, Pennsylvania 19109

MARGRET E. ANDERSON
Assistant Attorney General
MICHAEL VON MOSCHZISKER
Eastern Regional Director
Office of the Attorney General
Eastern Regional Office
Room 206 State Office Building
Philadelphia, Pennsylvania 19130

J. JUSTIN BLEWITT, JR.
Chief, Civil Litigation
Department of Justice
Harrisburg, Pennsylvania 17120

MARK SENDROW
Chief, Motions Division
Office of the District Attorney
2300 Centre Square West
Philadelphia, Pennsylvania 19102

Of Counsel:
MORGAN, LEWIS & BOCKIUS

Supreme Court, U. S.
FILED
JAN 21 1977
MICHAEL RODAK, JR., CLERK

PRESS OF ALLEN, LANE & SCOTT, INC. PHILADELPHIA

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Pursuant to Rule 35 of this Court, appellees file the within Motions to Dismiss and Affirm to present, prior to argument, intervening matters that were not available in time to have been included in the Brief of Appellees filed on December 22, 1976, which intervening matters make appropriate the dismissal of the appeal in No. 75-1691 and the affirmance of the appeal in No. 75-1698.

1. Motion to Dismiss No. 75-1691 Based Upon Mootness.

The only issue presented by the Jurisdictional Statement of appellants in No. 75-1691 is the claimed right of hospitals represented by the Delaware Valley Hospital Council to contract with Blue Cross subscribers in connection with hospital admissions during the period August 15, 1974 to August 2, 1975 and during the period of approximately 13 months subsequent to August 2, 1975, rather than being required to "contract" with appellee Blue Cross of Greater Philadelphia for hospital admissions during such periods.

On October 18, 1976 appellee Pennsylvania Insurance Department gave its approval (Exhibit A hereto) to a form of contract between appellants in No. 75-1691 and appellee Blue Cross. By interpretive letter dated November 17, 1976, said form of Blue Cross-

hospital contract was forwarded to the hospital parties (Exhibit B hereto). Such contract (Exhibit C hereto) was executed by all appellants in No. 75-1691 and by appellee Blue Cross on December 30, 1976, and is now in full force and effect.

The 1976 Blue Cross-hospital contract provides in pertinent part:

> "This Agreement shall commence on July 1, 1976 and expire on June 30, 1978, provided however, that if Act 94 of 1975 is no longer applicable to the termination of this Agreement it shall be automatically extended through June 30, 1979. This Agreement shall supersede all previous agreements between the parties hereto, although it is expressly agreed that the 1971 Hospital Agreement [exclusive of certain "hold down" provisions thereof] . . . shall apply to all admissions during the period July 1, 1974 [*i.e.*, the earliest date suggested by appellants as the expiration date of the 1971 Hospital Agreement] to June 30, 1976, inclusive . . ."

Section 21.1 (*infra* p. 37a). See also Section 21.2 (*infra* p. 37a), Exhibit B hereto (*infra* pp. 5a-6a), and Section 1.10-1.12 of Exhibit A to the 1976 Hospital Agreement (*infra* pp. 66a-69a).

By the terms of the 1976 Hospital Agreement quoted immediately above, appellants have now agreed that admissions during the two periods in controversy will be accounted for on the basis of a contract between Blue Cross and the hospitals. Thus, there would appear to be no relief to which appellants are entitled in view of their settlement of the controversy, and there is therefore no case or controversy before this Court.

2. Motion to Affirm No. 75-1698 Based Upon Intervening Circumstances.

Appellants in No. 75-1698 have appealed to this Court along with appellants in No. 75-1691 from an order denying, after notice and hearing, an injunction in a civil action, challenging the constitutionality of an Act of the Commonwealth of Pennsylvania (Act No. 94), required by Act of Congress to be heard and determined by a district court of three judges. 28 U.S.C. §§ 1253, 2281.

The appeal in No. 75-1698 raises an issue relating to certain contracts which were in existence on the August 2, 1975 effective date of Act No. 94, which issue is not affected by the 1976 Hospital Agreement executed by appellants in No. 75-1691. Thus, the appeal in No. 75-1698 is not moot, and appellants in No.

75-1698 retain their statutory right of direct appeal to this Court.

However, the difficult constitutional issue in the combined appeals in Nos. 75-1691 and 1698 is the validity of Act No. 94 as applied retroactively to hospital admissions prior to August 2, 1975, and such issue is confined to the appeal, now moot, in No. 75-1691. Accordingly, the mootness of the appeal in No. 75-1691 constitutes an intervening circumstance making the questions on which the decision of the remaining cause depends so unsubstantial as not to need further argument. See Rules 15(1)(f) and 16(1)(c).

3. Relief Requested.

The established practice of this Court in dealing with a civil case such as No. 75-1691 from a court in the federal system which has become moot pending review by the Court is to reverse or vacate the judgment below and remand with a direction to dismiss. *United States* v. *Munsingwear, Inc.*, 340 U.S. 36, 39 (1950). However, such a step would not be appropriate in the instant situation, since a dismissal of the case by the lower court would deprive appellants in No. 75-1698 of the basis for their appeal to this Court. Accordingly, appellants would respectfully suggest that this Court dismiss only the appeal in No. 75-1691 as moot, and that the Court enter an

order vacating only so much of the order below as applies to appellants in No. 75-1691.*

4. Further Information.

On December 30, 1976, counsel for appellees contacted counsel for appellants in No. 75-1691 by telephone with the suggestion that the cause in No. 75-1691 be disposed of by an agreement to dismiss under Rule 60(1), and with the offer to settle the costs issue under said Rule by having appellants and appellees absorb the costs which they had respectively incurred thus far (recognizing that appellees would be entitled to recover from appellants in No. 75-1698 the costs applicable to the appeal in No. 75-1698 if the judgment in that case were to be affirmed). On January 6, 1977, a draft copy of a Suggestion of Mootness was served on counsel for appellants. Although there have been communications between counsel in the interim, no agreement to dismiss under Rule 60(1) has been reached.

In the interests of bringing the aforesaid settlement in No. 75-1691 promptly to the attention of this Court

* If appellees fully prevail in their within motions an appropriate disposition in this Court would be: (1) to affirm the judgment of the district court insofar as it relates to the controversy between appellees on the one hand and The Williamsport Hospital and The Hospital Association of Pennsylvania (appellants in No. 75-1698) on the other, and (2) to vacate the judgment of the district court insofar as it relates to the controversy between appellees on the one hand and the balance of the plaintiffs below (appellants in No. 75-1691) on the other, with direction to dismiss the action as to all such parties in No. 75-1691.

in light of the present status on the calendar of Nos. 75-1691 and 1698, appellees have accordingly submitted the within Motions to Dismiss and Affirm under Rule 35.

Respectfully submitted,

WILLIAM E. ZEITER

ROY K. MEILMAN
2100 The Fidelity Building
Philadelphia, Pennsylvania 19109

MARGRET E. ANDERSON
Assistant Attorney General

MICHAEL VON MOSCHZISKER
Eastern Regional Director
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J. JUSTIN BLEWITT, JR.
Chief, Civil Litigation
Department of Justice
Harrisburg, Pennsylvania 17120

MARK SENDROW
Chief, Motions Division
Office of the District Attorney
2300 Centre Square West
Philadelphia, Pennsylvania 19102

Of Counsel:
MORGAN, LEWIS & BOCKIUS

Exhibit A

INSURANCE DEPARTMENT
Harrisburg

(Letterhead)

October 18, 1976

David S. Markson, Vice President
and Corporate Secretary
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, PA 19107

Dear Mr. Markson:

Re: SUPPLEMENT TO BLUE CROSS FILINGS No. 2-P-76
AND No. 3-P-76

We are approving the captioned supplement which consists of the final agreement negotiated with certain hospitals represented by the Delaware Valley Hospital Council. A copy of the agreement bearing our approval stamp is enclosed for your file purposes.

Very truly yours,

/s/ JACOB A. LAZERSON

JACOB A. LAZERSON, Actuary
Bureau of Regulation of Rates
and Policies

Exhibit A

BLUE CROSS OF GREATER PHILADELPHIA
1333 Chestnut Street, Philadelphia, Pennsylvania 19107

(Letterhead)

September 1, 1976

Hon. William J. Sheppard
Insurance Commissioner
Pennsylvania Department of Insurance
Finance Building—Room 108
Harrisburg, Pennsylvania 17120

Re: SUPPLEMENT TO BLUE CROSS FILINGS No. 2-P-76 AND No. 3-P-76

Dear Commissioner Sheppard:

As you will recall, on June 1, 1976 we formally amended our Filings No. 2-P-76 and No. 3-P-76 which were originally filed on April 28, 1976. In our amendment of June 1, 1976 we submitted to you a draft form of a newly negotiated Agreement for certain hospitals represented by the Delaware Valley Hospital Council. As we indicated to you in that letter of June 1, 1976 and in our previous letter of May 26, 1976, certain minor matters, principally of a nonsubstantive nature, would be negotiated and the finalized Agreement would be submitted to you by way of supplement.

Enclosed herewith please find two copies of the final version of the Agreement referred to in our letters of June 1, 1976 and May 26, 1976. We respectfully request your prompt approval of this supplement consisting of the finalized Agreement.

Exhibit A

We are also enclosing two copies of this letter so that your approval may be noted thereon and one copy returned for our file.

Respectfully yours,

/s/ DAVID S. MARKSON

DAVID S. MARKSON
Vice President and
Corporate Secretary

Approved, Effective 10/18/76
PENNSYLVANIA INSURANCE DEPARTMENT
By /s/ JACOB A. LAZERSON

Exhibit B

MORGAN, LEWIS & BOCKIUS

(Letterhead)

November 18, 1976

Frank H. Abbott, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Re: 1976 HOSPITAL AGREEMENT

Dear Mr. Abbott:

Enclosed herewith is a copy of the letter transmitted by Blue Cross of Greater Philadelphia to the various hospitals listed on page 9 of the subject agreement. In accordance with our prior discussions it has been agreed that your firm, as counsel to the plaintiffs in *Riddle Memorial Hospital, et al.* v. *Blue Cross of Greater Philadelphia*, No. 2187, October Term 1976, will immediately file with the Clerk of the Superior Court of Pennsylvania a praecipe withdrawing their appeal. In so acting it is understood and agreed by the parties thereto that the withdrawal of the appeal shall not limit the rights of any party to this litigation or any other person to challenge the validity of the assignment prohibition clause in Blue Cross subscriber agreements at any time in the future, and accordingly, the parties agree that the Declaratory Judgment issued in *Riddle Memorial Hospital et al* v. *Blue Cross of Greater Philadelphia* (Delaware County, Number 1667 of 1975) shall not be asserted by any party, its successors or assigns, as *res judicata* or collateral estoppel in any subsequent litigation involving future assignments of Blue Cross benefits. This settlement does not preclude either party from relying upon the above-captioned decision as precedent in support of its position

Exhibit B

in any future litigation involving assignment of Blue Cross benefits.

In order that we may close our files with regard to the *Riddle* litigation, please forward a copy of the praecipe withdrawing the appeal to the undersigned at your earliest opportunity. Thank you for your kind cooperation and assistance in bringing this matter to a successful conclusion.

Very truly yours,

/s/ ALLEN W. STEWART

ALLEN W. STEWART

BLUE CROSS OF GREATER PHILADELPHIA
1333 Chestnut Street, Philadelphia, Pennsylvania 19107

(Letterhead)

November 17, 1976

Transmitted herewith are three copies of the 1976 Hospital Agreement which has received the approval of the Pennsylvania Insurance Department. After this contract has been approved by your institution, please return two executed copies to the undersigned. At such time, and as a condition precedent to Blue Cross' acceptance of the Agreement, at least 90% of the hospitals being offered this contract have returned executed copies (which hospitals are identified on pages A-9 and A-10 to Exhibit A of the Agreement), Blue Cross will deliver a fully executed copy of the Agreement for your files.

Since several questions have been raised with regard to the application of subsection 21.2 of the Agreement, counsel for both the hospitals being offered this contract and Blue Cross, have agreed that this provision shall be interpreted as described below, and your execution and de-

Exhibit B

livery of the Agreement to Blue Cross shall be considered as your acceptance of, and agreement to be bound by, said interpretation.

> Subsection 21.2 shall be construed to provide that in making final settlement for fiscal years 1975 and 1976, all indemnity payments made by Blue Cross to Subscribers on account of Covered Services furnished by the Provider during the period the Provider was a "Nonmember Hospital," as defined in their respective Subscription Agreements, shall be deducted from allowable costs for such fiscal years. If, after a reasonable collection effort has been made (as defined in the now current Medicare regulations), a hospital is unable to recover a portion of the indemnity payments made to Subscribers, Blue Cross shall credit against the aforesaid deduction from allowable costs a sum equal to one half of the uncollected amount of such indemnity payments; provided, however, the total amount to be credited all hospitals contracting under the Agreement shall not exceed $300,000.

In the event the total credit, determined as above, exceeds $300,000, the credit shall be recomputed so as to distribute such *pro rata* to all contracting hospitals. The foregoing credit shall be paid by Blue Cross at such time as final settlement is made for all affected hospitals.

This letter has been reviewed and approved by counsel to the Delaware Valley Hospital Council and I trust you will find such satisfactory. We look forward to working with you in the future.

Very truly yours,

Howard W. Baker, M.D.
Vice President

Exhibit C

HOSPITAL AGREEMENT
July 1, 1976
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Exhibit C

HOSPITAL AGREEMENT

The undersigned hospital (hereinafter called the "Provider") and Blue Cross of Greater Philadelphia (hereinafter called "Blue Cross"), intending to be legally bound, hereby enter into this Agreement. As part of its undertaking, Blue Cross agrees on behalf of each subscriber to the Hospitalization Plan of Blue Cross, Health Service, Incorporated or other Hospital Service Plan as designated and approved by Blue Cross (hereinafter called "Subscriber") to make those payments required hereinafter and provide its assistance to all area health care institutions in developing procedures and practices to further the goal of a consumer-responsive health care delivery system. The Provider agrees to utilize its best efforts to provide a viable and economical health care delivery system to satisfy the medical needs of the community which it serves.

Section 1. Provider Services and Facilities.

In consideration of the agreement by Blue Cross to reimburse the Provider as hereinafter described, the Provider agrees:

1.1. To furnish, as applicable, to each Subscriber those hospital services and facilities whereby there may be administered certain medical services incident to hospitalization of the type which Blue Cross is obligated to provide Subscribers (hereinafter called "Covered Services").

1.2. Covered Services shall be available to each Subscriber beginning with the effective date of his Subscription Agreement with Blue Cross (hereinafter called "Subscription Agreement"), except that any waiting periods specified therein may be modified or waived by Blue Cross in such cases as it may determine.

Exhibit C

1.3. Covered Services shall be provided to each Subscriber without an advance deposit or charge therefor to the Subscriber except to the extent of any co-payment or deductible amount provided in his Subscription Agreement, and that, except as aforesaid, Provider will accept the reimbursement provided for herein as the full contract payment of Blue Cross for such Covered Services.

1.4. Its charges for all services to Subscribers shall be the same as its charges to all patients for the same services. The Provider shall file a current schedule of such charges with Blue Cross and furnish written notice to Blue Cross of any modification of such charges at least five days prior to the effective date of such modification.

Section 2. Reimbursement by Blue Cross.

Blue Cross agrees to reimburse the Provider for Subscriber admissions on or after the effective date of this Agreement for those Covered Services furnished to Subscribers upon receipt of the medical records, if requested, and bills therefor, as follows:

2.1. Reimbursement will be made in accordance with the terms and conditions set forth in Exhibit A attached hereto and made a part hereof, except as otherwise provided herein.

2.2. If Covered Services are furnished as stated dollar allowances or indemnities, except for private room accommodations and indemnities for certain services of physicians, payment of such allowance or indemnity shall constitute final payment by Blue Cross and such Covered Services shall be excluded from any reimbursement calculation required by Exhibit A hereof although such reimbursement shall not preclude Provider from collecting the balance of its charges for such Covered Services from Subscribers.

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2.3. If all or any part of the Covered Services provided Subscribers admitted on or after the effective date of this Agreement is ultimately determined not to be medically appropriate as a result of formal medical review, the Provider shall not charge either Blue Cross or the Subscriber for the medically inappropriate portion of such services. For the purposes of making the foregoing determination, Blue Cross shall advise the Provider's Utilization Review Committee of any case which it has determined not to be medically appropriate. If the Utilization Review Committee concurs with Blue Cross, such determination will be deemed conclusive unless the attending physician or a consulting physician appeals, or if upon review the representatives of Blue Cross and Provider's Utilization Review Committee cannot reach a mutually agreeable result as to a given case, then such case shall be referred, at the expense of Blue Cross, to the appropriate committee of the Philadelphia County or State Medical Society or State Osteopathic Medical Association (or such county committee as shall hereafter be created and approved by the Provider and Blue Cross), as applicable, for its determination as to the medical appropriateness of the services in question. It is agreed that the determination of such medical society shall be binding upon both Blue Cross and Provider. If all or any part of a given hospital admission or length of stay is determined not to have been medically appropriate as a result of the foregoing review procedure, but medically appropriate services were furnished which should have been provided on an outpatient basis, Blue Cross shall reimburse Provider for any such Covered Services on an outpatient basis to the extent provided in the Subscriber's Subscription Agreement. However, if the Subscriber insists on hospitalization against the advice of his physician, the Provider may charge any unreimbursed charges to the

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Subscriber, provided, the Provider has supplied appropriate written evidence to Blue Cross that the Subscriber has been advised of his financial responsibilities.

2.4. For the purposes of the foregoing, the term "medical appropriateness" shall be interpreted to mean:

1. Hospitalization which is provided at the situs level furnishing necessary Covered Services at the lowest cost consistent with the services rendered.

2. Hospitalization limited in scope and extent to that medically justified by diagnosis and particular patient's condition.

3. Hospitalization limited in length of stay to that required by the patient's diagnosis as reviewed and approved by the Utilization Review Committee.

4. Hospitalization which is medically required and consistent with the requirements of the: (a) Public Law 89-97, as amended by P.L. 92-603, (b) Pre-Discharge Utilization Review Program of the Commonwealth of Pennsylvania for recipient's under Title XIX of the Medicaid Program, (c) Pennsylvania Department of Public Welfare as promulgated in the Welfare Assistance Manual at Section 9421.52 and (d) Joint Commission on Accreditation of Hospitals.

Section 3. Utilization Review.

The Provider shall maintain or create and maintain, as appropriate, a program of utilization review which satisfies the standards of either the Basic or Advanced Utilization Review Programs described below. If during the term of this Agreement the Provider desires to change Programs it shall give thirty (30) days prior written notice to Blue Cross.

Except as provided in subsections 3.2.1 and 3.2.2, the Provider shall forward to the Reimbursement Review Committee (RRC) for approval the Utilization Review Plan which it will employ to satisfy the requirements of this Section, as well as any subsequent changes thereto with a copy of such plan to be forwarded to Blue Cross.

3.1. The Basic Utilization Review Program.

The Provider shall appoint a Utilization Review Committee whose membership includes the Provider's Administrator or his designee, and at least one non-physician member of its governing board. The Committee shall be responsible for developing and implementing a program of utilization review.

3.1.1. *Scope of Program.* The Provider will strive to improve the effectiveness of its procedures for utilization review by exerting special efforts in reviewing:

(a) Lengths of stay;

(b) Promptness of service;

(c) Medical necessity of admissions;

(d) Use of consultations;

(e) Implementation of effective discharge planning; and

(f) Such other matters and procedures as will minimize the unnecessary use of expensive medical resources while ensuring proper patient care.

3.1.2. *Review of Admissions.* The Provider shall have all hospitalizations, whether elective or not, reviewed by the Utilization Review Committee within two (2) working days (excluding Saturday, Sunday and holidays) after admission. At the time of the review an expected length of stay for each patient shall be established based upon

the admitting diagnosis and the average length of stay applicable to like patients as prepared by the Hospital Utilization Project or the Professional Activity Study. If the Provider does not subscribe to either service, Blue Cross will provide similar data regarding length of stay to the Provider.

3.1.3. *Monitoring and Evaluation of Cases.* Following the initial review by the Utilization Review Committee, the Provider shall have all cases monitored on a continuing basis and shall evaluate all Subscriber cases at least one (1) working day prior to the date established pursuant to subsection 3.1.2 above, in order to establish the medical necessity of continued hospitalization.

(a) If further hospitalization beyond that period originally established is determined to be medically appropriate, the Utilization Review Committee shall establish a new expected length of stay consistent with its evaluation of the case. At the expiration of any expected stay, a new evaluation shall be made.

(b) If further hospitalization is not found to be medically appropriate, the Provider shall so advise the Subscriber and the attending physician, and give written notice to the Subscriber that he, and not Blue Cross, will be responsible for any expense incurred for hospitalization beyond the originally approved length of stay. The format of the notice to be so given shall have received the prior written approval of Blue Cross.

3.1.4. *Reporting Procedures.* Blue Cross shall furnish a quarterly report to the Provider listing the Provider's average length of stay for Subscribers according to the most frequent diagnoses in this general geographic area. If such report indicates that the Provider's experienced length of stay for any diagnosis is more than ten per cent

longer than the area average, the Utilization Review Committee shall determine the basis for this variance and submit a written explanation of the causes and suggested corrective measures to its governing body with a copy to RRC. All comparisons above shall be made with reference to data for patients under age 65.

3.1.5. *Additional Costs.* Any additional cost of the Utilization Review Program which Provider incurs as a direct result of an expansion, increase or modification of its existing services in order to satisfy the requirements set forth in subsections 3.1.2, 3.1.3 and 3.1.4 shall be a reimbursable cost hereunder and treated as a new service.

3.2. Advanced Utilization Review Program. Provider may elect in lieu of the Basic Utilization Review Program to establish and maintain an Advanced Utilization Review Program similar to the Quality Assurance Program ("QAP") of the American Hospital Association by delivering written notice of such election to Blue Cross.

3.2.1. *Implementation of Inpatient Program.* Commencing the date on or after July 1, 1976 that the Provider meets the standards of an Advanced Utilization Review Program approved by Blue Cross, with the right of the Provider to appeal Blue Cross' rejection pursuant to Section 20, and continuing so long as Provider maintains such program, Blue Cross shall provide developmental financing to Provider in the form of an unrestricted grant equal to $12.50 per inpatient service benefit Blue Cross paid case. These grants shall be paid monthly to the Provider by Blue Cross. Further, during such period, reimbursement shall not retrospectively be denied by Blue Cross for admissions reviewed pursuant to such program.

3.2.2. *Outpatient Utilization Review Program.* Blue Cross will make available, as provided below, unrestricted

developmental grants to a Provider which has in effect an Advanced Utilization Review Program, as of a date, on or after July 1, 1976, that the Provider implements an Outpatient Utilization Review Program approved by Blue Cross, with the right of the Provider to appeal Blue Cross' rejection pursuant to Section 20.

3.2.3. *Calculation of Grant Payments.* The grants provided by subsection 3.2.2 shall be paid monthly by Blue Cross to Provider, as appropriate and continuing so long as Provider maintains such program, on the basis of $2.50 per Emergency Room Blue Cross paid case and $6.25 per service benefit Blue Cross paid case that is handled in the Provider's Short Procedure Unit, as such is defined and certified for such payments pursuant to Section 25 hereof.

3.3. Maintenance of Records.

The Provider shall maintain detailed records of its activities described in this Section to permit comprehensive review by Blue Cross.

3.4. Provider Designated PSRO Status.

A Provider participating in a designated Professional Standards Review Organization program to the extent of (i) admission certification, (ii) continued stay review, and (iii) medical care evaluation studies may apply to the RRC for waiver of the requirements of subsections 3.1.2, 3.1.3 and 3.1.4.

Section 4. Calculation of Inpatient Days.

4.1. *Inpatient Day.* For purposes of this Agreement, an inpatient day begins at midnight and ends twenty-four hours later. The midnight-to-midnight method is to be used in reporting days of care for Subscribers, even if the Provider uses a different definition of inpatient day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. The day of discharge or a day on which a patient begins a leave of absence is not counted as a day, but this limitation does not apply to covered ancillary services on the day of discharge. If admission and discharge occur on the same day, such day is considered a day of admission and counts as one inpatient day.

4.2. *Late Discharge.* If a Subscriber continues to occupy his accommodations beyond the Provider's regular discharge hour, after being advised prior to such discharge hour that further hospitalization is not required, the Provider may charge the Subscriber for any unreimbursed charges applicable to such continued stay.

4.3. *Leave of Absence.* The day on which a Subscriber begins a leave of absence shall be treated as a day of discharge and not counted as an inpatient day unless he returns to the Provider by midnight of the same day. The day the Subscriber returns to Provider from a leave of absence is treated as a day of admission and counted as an inpatient day if he is physically present at midnight of such day.

4.4. *Limited Number of Days.* If the Subscription Agreement provides a limited number of days for certain surgical cases, the day on which the operation is performed is included in the days allowed the Subscriber under the Subscription Agreement.

Section 5. Accommodations.

Semi-private accommodations including routine general services, which term shall mean accommodations having two, three or four beds per room, are Covered Services for which the Provider shall be entitled to be

reimbursed as provided in this Agreement. A single occupancy room offered as a semi-private accommodation shall be considered a semi-private room for reimbursement purposes, provided the charge for such is the same as that for Provider's other semi-private accommodations. When accommodations other than semi-private are furnished, reimbursement for such will be adjusted in the following manner:

5.1. Private Rooms Medically Necessary.

5.1.1. Private rooms or other accommodations, including intensive care and other specialty service facilities more expensive than semi-private, will be Covered Services only when such accommodations are medically necessary. Such accommodations shall be considered medically necessary when the attending physician has noted on the Subscriber's medical chart that the Subscriber's condition requires that he be isolated for his own health or that of others.

5.1.2. Isolation may be necessary when treating certain communicable diseases in order to avoid cross-infection, as well as other physical and mental conditions when privacy is necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

5.2. Private Rooms Not Medically Necessary.

5.2.1. When accommodations more expensive than semi-private are furnished the Subscriber at the time of admission because less expensive accommodations are not available, Blue Cross will reimburse the Provider on the same basis as is applicable to semi-private accommodations.

5.2.2. When accommodations more expensive than semi-private are furnished the Subscriber at his request

and in the absence of medical appropriateness, the Provider may charge the Subscriber for the difference between the charges for the accommodations furnished and the credit for those accommodations included in Covered Services. No such charge may be made to the Subscriber unless he requested the more expensive accommodations with knowledge that he would be charged the differential.

5.3. Wards.

5.3.1. When ward accommodations, which term shall mean five or more beds per room, are furnished the Subscriber at his request, or when semi-private accommodations are not available at the time of his admission, reimbursement shall be made on the same basis as is applicable to semi-private accommodations; however, it is understood and agreed that the Subscriber must be moved to semi-private accommodations when they become available unless the Subscriber specifically requested ward accommodations at the time of his admission.

5.3.2. When ward accommodations are furnished neither at the Subscriber's request, nor due to the lack of available semi-private accommodations, the reimbursement for ward accommodations shall be on the same basis as is applicable to semi-private accommodations, minus a "ward differential" which shall be computed by calculating the difference between the Provider's customary charges for semi-private accommodations at its most prevalent rate in effect at the time of the Subscriber's admission (the rate which applies to the greatest number of semi-private beds) and the charge customarily made for the ward accommodation furnished the Subscriber.

5.3.3. When ward accommodations are furnished not at the Subscriber's request, or due to the lack of available semi-private accommodations, for a period exceeding three

days, the entire admission shall be considered a ward admission and all days charged for this admission shall be adjusted in the manner described in subsection 5.3.2 above. However, when ward accommodations are initially furnished because semi-private accommodations are unavailable and the Subscriber is subsequently moved to a semi-private accommodation within three days following the date of admission, the entire admission shall be considered semi-private.

5.4. Specialty Service Facilities. Reimbursement for the use of intensive care facilities and other specialty service facilities will be made in accordance with subsection 5.1 when such are medically necessary, except where explicitly excluded from Covered Services by the applicable Subscription Agreement.

Section 6. Provider Employees and Private-Duty Nursing.

The reasonable cost of Covered Services rendered by all personnel engaged by the Provider (either on a salary or fee-for-service basis), under arrangements which provide for billing to be made by the Provider, shall be included as a reimbursable cost hereunder.

The cost of private-duty nurses or private-duty attendants (registered professional nurses, licensed practical nurses, or any other trained attendants) whose services are rendered to and restricted to a particular Subscriber by arrangement between the Subscriber and the private-duty nurse or attendant is not reimbursable hereunder.

Section 7. Covered Services Obtained from Outside Sources.

In order to avoid unnecessary duplication of services, the Provider shall institute procedures whereby Covered

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Services, including timely tests and other diagnostic and therapeutic procedures, performed by outside sources such as pathologists, radiologists and other hospitals, which are licensed pursuant to applicable state regulation, meet the Provider's established quality standards and have been approved by the Provider, will be accepted for use in rendering patient care. Provider shall institute such procedures as may be required for the reasonable regulation of its medical staff directed toward the continued concentration of these tests within its facilities so as to prevent undue escalation of Provider's unit cost for such services. Except for those certain medical services incident to hospitalization provided for in Section 9 hereof, the Provider may not allow those furnishing Covered Services to bill Subscriber for such services.

Where Covered Services are obtained for Subscribers from outside sources, reimbursement hereunder shall be made on the same basis as though these services had been performed by the Provider. In those cases where the Provider has consolidated any of its ancillary services with those of another health care institution, reimbursement for the Covered Services performed there shall be on the same basis as if such services had been rendered through the Provider's own facilities.

Section 8. Physician Recommendations.

Covered Services shall be rendered to a Subscriber only upon the recommendation of a physician who is either a member of the medical staff or acceptable to the Provider and shall continue only during such period as the Subscriber is in need of hospital care for the treatment of illness or bodily injury and under the care of such a physician.

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Section 9. Arrangements Between Providers and Physicians.

9.1. *Reimbursement by Blue Cross.* The Provider and physicians rendering those certain medical services provided for herein may commence, continue, revise or terminate arrangements between them for those services as in their discretion they see fit. In determining reimbursement pursuant to Exhibit A, Blue Cross will recognize the applicable arrangements prevailing between the Provider and those physicians who render certain covered medical services when incident to the hospitalization of Subscribers as provided hereunder.

9.1.1. Under such arrangements when the bills for such covered medical services are included in the Provider's bills rendered to all patients, the compensation paid to physicians rendering those services shall be included as a part of the Provider's cost of those services. After the allocation of costs in accordance with subsection 2.3 of Exhibit A, Part I, the determination of cost of Covered Services to Blue Cross Subscribers shall be made in accordance with subsection 2.2 of Exhibit A, Part I.

Blue Cross will pay the Provider the cost of such covered medical services as determined above, thereby indemnifying the Subscriber against such bills, and in addition will pay to the Provider the amount otherwise payable to the Provider hereunder for the hospital services rendered by it.

9.1.2. Under such arrangements when the bills for such covered medical services are billed directly to all patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills.

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The Provider also may have incurred unreimbursed cost in providing facilities for the rendering of such covered medical services. After the allocation of these costs, if any, in accordance with subsection 2.3 of Exhibit A, Part I, the determination of the inpatient cost of Covered Services to Subscribers shall be made in accordance with subsection 2.2 of Exhibit A if the Provider has either: (a) complete information with respect to the regular charges for those certain medical services for both Subscribers and all other patients who receive the services; or (b) complete information with respect to regular charges of the Provider made in connection with the rendering of the certain medical services for both Subscribers and all other patients who receive these services. In the event the information required in (a) or (b) above is not available, the determination of inpatient cost of Covered Services to Subscribers shall be made as follows: (i) on total occasions of inpatient medical service or a statistical basis of allocation approved for such use under Title XVIII of Public Law 89-97 (hereinafter called "Medicare") apportioned between Subscribers and all other patients or, if this information is not complete, (ii) on total inpatient admissions apportioned between Subscribers and all other patients. Blue Cross will pay the Provider the cost of such covered medical services as determined above and in addition will pay Provider the amounts otherwise payable hereunder for the hospital services rendered by the Provider.

9.1.3. Under such arrangements when the bills for any one of the certain medical services incident to hospitalization are included in the Provider's bill rendered to some patients, and when bills for such medical services are billed directly to some patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it as are billed directly by such

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physicians, of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills. The Provider's cost of such medical services shall be subdivided into those applicable to services billed for by the Provider and those applicable to services billed for by the physician. The cost of covered medical services for each of these categories shall then be determined in accordance with the methods described in subsections 9.1.1 and 9.1.2 above, as appropriate. Blue Cross will pay the Provider its cost as so determined.

9.1.4. Under arrangements where the bills for certain medical services incident to hospitalization have been billed directly to patients by such physicians, the Provider may have incurred cost in providing the facilities for the rendering of such covered medical services in return for an agreed upon payment by the physician to the Provider. Payments received by the Provider under such an arrangement shall be treated as a reduction of the Provider's allowable cost to the extent of such cost.

9.1.5. In the event the Provider has elected to be reimbursed on a prospective rate basis in accordance with Part II of Exhibit A, the Provider agrees that: (a) the amounts payable directly to physicians by Blue Cross under subsections 9.1.2 and 9.1.3 shall be excluded from the determination of such gross prospective rate; (b) the amounts otherwise payable by Blue Cross to the Provider for costs the Provider may have incurred in providing facilities for rendering medical services pursuant to subsections 9.1.1, 9.1.2 and 9.1.3 shall be incorporated from the determination of such gross prospective rate and no additional payment will be made by either Blue Cross or the Subscriber; and (c) the payments received by the

Provider pursuant to subsection 9.1.4 shall be deducted in making the determination of such gross prospective rate otherwise payable to the Provider by Blue Cross. To ensure the gross prospective rate adequately reflects the costs to Provider of the various arrangements which it has with physicians rendering covered medical services, Provider shall notify Blue Cross of any modification or amendment to such arrangements, and in such event Blue Cross will make appropriate changes in the gross per diem rate.

9.2. *Reporting Requirements.* The Provider shall report annually to its governing board or a committee thereof the actual compensation paid by Provider to the anesthesiologists, pathologists and radiologists on its staff for services to the Provider's inpatients and outpatients.

Section 10. Cost Saving Programs.

Provider shall, to the extent practicable, actively participate on a continuing basis in the following Blue Cross programs or equivalent programs approved by Blue Cross which seek to encourage the effective use of Provider's inpatient facilities: (a) preadmission testing; (b) short procedure unit as described in Section 25, (c) home care service, and (d) discharge planning; and maintain records of its activity in these areas.

Section 11. Systems Analysis.

In order to provide a means whereby more efficient methods of operation may be developed and implemented, the Provider shall assign one or more administrative employees the responsibility for systems analysis.

Section 12. Patient Information.

A program will be continued or established which will supply all patients with information regarding Provider's

procedures and practices. The intent of the program will be to insure that patients are advised of the Provider's facilities, services and practices in a timely fashion. In this regard, a patient Bill of Rights may be developed for adoption by individual Providers after adaptation to their particular institutions.

Provider shall submit its procedures which comply with the foregoing to the RRC within thirty days following execution of this Agreement, a copy of the patient booklet (and any subsequent changes thereof) used by Provider to furnish the foregoing information, and the form of questionnaire which Provider will supply each patient at or before discharge requesting information as to care and treatment while hospitalized at Provider.

Section 13. Generic Equivalents.

13.1. If the Provider has on its staff a full-time pharmacist, it shall maintain a Drug Formulary Committee either of its own, or in cooperation with area hospitals, which will develop and implement a program designed to ensure that drugs are dispensed by generic rather than brand name when the less expensive generic equivalent is available. As part of this program, Provider will utilize prescription blanks which contain a printed legend authorizing the pharmacy filling the prescription to dispense, when available, generic equivalents for the brand name drugs prescribed.

13.2 In developing the drug formulary program, it is recognized that in certain situations, it may be necessary and prudent for the prescribing physician to designate a specific brand name drug due to compounding differences in the generic equivalent. To allow for these unusual situations the Provider may make suitable internal

arrangements, provided the physician requiring such brand name drugs makes an appropriate notation on the patient's medical chart or similar record of his request.

Section 14. Cooperation Between the Provider and Blue Cross.

The Provider and Blue Cross agree to cooperate fully with each other in administering the various provisions of this Agreement. To that end, Blue Cross shall promptly furnish Provider such information as is necessary to verify the payments made to it by Blue Cross. Blue Cross shall submit to the Provider upon request: (a) monthly financial statements; (b) annual balance sheet, as well as an income and surplus statement, both certified by independent accountants within thirty days after the receipt thereof from the accountants; and (c) copies of all transactions and financial operating data having a bearing on this Agreement. Similarly, Provider shall submit to Blue Cross all cost information regarding its operations which is necessary for the administration of this Agreement, and will permit Blue Cross to examine and audit all records, documents and financial and statistical data which may relate to reimbursable costs as determined herein.

Section 15. Purchasing Procedures.

Provider's governing board, or a committee thereof, shall review the practice and procedures of its purchasing officers and agents to insure that the "Prudent Buyer Concept", as defined in the current Medicare regulations, is employed when making purchases of equipment, supplies and services. The reports and statistical data used by the purchasing officers and agents shall be made available to Blue Cross for review.

Section 16. Safety Control Program.

In order to maintain a comprehensive program of loss control and prevention, the Provider shall establish or maintain, as applicable, a safety program based on the American Hospital Association's "Hospital Safety Manual" and incorporating the principles set forth in the attached Exhibit C.

Section 17. Public Disclosure.

Provider and Blue Cross mutually agree that the public at large has a significant and continuing interest in the development of an effective, cost-efficient medical service program which is responsive to consumer needs. To ensure that the public is advised of the plans, programs and undertakings of both the Provider and Blue Cross, each party agrees that during the term of this Agreement they shall individually make available information relating to costs, facilities, services available and other pertinent financial and statistical data with respect to their own operation, and continue appropriate measures to assure adequate consumer participation in their respective activities.

Section 18. Accreditation.

In order to encourage the Provider to satisfy recognized minimal standards in providing patient care, Provider agrees to strive for accreditation by the Joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association. In the event the Provider is not so accredited, Blue Cross shall have the right, notwithstanding any other provision contained herein, to terminate this Agreement upon giving the Provider thirty (30) days prior written notice of such intent to terminate.

Section 19. Areawide Planning of Health Care Facilities.

19.0. *Designation of Planning Agency.* The Agency which will perform the various planning and evaluation functions pursuant to this Section 19 shall, effective July 1, 1976, be the Regional Comprehensive Health Planning Council, Inc. (RCHP) which has signified its consent to do so by executing a master agreement defining its duties, obligations and responsibilities in this area. At such time as: (1) the performance by RCHP of those functions described in this Section 19 are recognized by the Federal Government pursuant to federal law as being able to be adequately performed by, and are reassigned to, a Health System Agency (HSA) or other federally designated agency (Successor Agency) operating in the county in which the Provider is located, and (2) the Successor Agency agrees to undertake the performance of all or any portion of those functions described in subsections 19.1, 19.2, 19.3 and 19.5, these functions shall be reassigned to the Successor Agency.

In the event that upon application by either Blue Cross or the Provider it is determined by mutual agreement or an arbitrator assigned from the Appeals Panel, described in Section 20, that any of the functions required to be performed by the Agency are no longer being performed, the performance of any such function shall be reassigned to the Reimbursement Review Committee (RRC), described in Section 24, which shall then retain a staff, or contract assistance, as the RRC deems necessary to assist it in the performance of such function. In the event the RRC is unable to reach a majority decision as to any matter referred to it for performance hereunder, the RRC will be joined by a member of the Appeals Panel and a decision made which shall be final and binding on both the Provider and Blue Cross. Subsequent to any assignment of function to the RRC, upon the application

of Blue Cross or Provider, the function or functions shall be reassigned to the RCHP, HSA or Successor Agency upon determination by the RRC that such proposed assignee agency is willing and prepared to perform the function sought to be reassigned. Whenever the RRC is performing a function under this Section 19, it shall be considered an Agency for purpose of this Section 19.

19.1. *Major Construction of Facilities.* If the Provider undertakes any project for the replacement or expansion of its facilities and equipment at an estimated cost in excess of $100,000 it will submit such project to the Agency for review prior to the letting of contracts therefor.

19.2. *Expansion of Certain Services.* If the Provider undertakes a project to provide either a new service listed below or expand an existing service listed below in such a way as to require in any one fiscal year additional space (beyond that theretofore used for such service) greater than 10% of the space theretofore so used, it will submit such project to the Agency prior to the letting of contracts therefor. The services referred to in this subsection are the following: (a) megavoltage radiation services; (b) open-heart surgery services; (c) obstetrical services; (d) pediatric services; (e) operating room services; (f) emergency care service; (g) diagnostic radiological services; (h) hemo-dialysis services; and (i) burn treatment services.

19.3. *Change of Function.* In addition to the requirements set forth in subsections 19.1 and 19.2, if the Provider has obtained the prior endorsement of the Agency for a given facility and desires within three years of such endorsement to change the function of the facility, or a substantial portion thereof, it shall submit and obtain the

endorsement of the Agency for such change prior to the implementation thereof.

19.4. *Denial of Reimbursement.* If the Agency refuses to endorse a project reviewed by it pursuant to subsection 19.1, 19.2 and 19.3 and the Provider, nevertheless, carries out the project, Blue Cross reimbursement to the Provider will be calculated without any allowance for the depreciation or interest expense with respect to the facilities of such project or the costs of services supplied by such project.

19.5. *Periodic Evaluation.* The Provider shall permit the Agency, during the term of this Agreement, to evaluate once every three years the need for the existing facilities of, and services supplied by, the Provider. The evaluation shall include a review of all facilities to determine if such conform to the then current requirements for new construction in respects which render them unsafe for patients. If the report of the Agency submitted to Blue Cross and the Provider recommends that a facility or service of Provider is no longer needed, it shall specify a reasonable time period by the end of which the facility or service, must be eliminated. Similarly, if the report states that a facility is unsafe, it shall specify a reasonable time period by the end of which the facility must be made safe or eliminated. After the end of a period so specified, Blue Cross reimbursement to the Provider shall be calculated without any allowance for the cost of facilities or services not eliminated or made safe in accordance with such evaluation, unless Provider is expressly prohibited from eliminating such facilities or services by law.

The Periodic Evaluation function required by this Section 19.5 may be accomplished by the Agency utilizing procedures mandated by federal law, as implemented by federal regulations and applicable state legislation, in lieu

of the procedure herein specified, provided that it is determined upon the application of Provider or Blue Cross by the RRC that such alternative procedures provide an equivalent evaluation function.

19.5.1. *Appeals.* In the event the Provider or Blue Cross does not agree with the decision of the Agency in connection with any function performed by the Agency other than that performed pursuant to the mandate of federal law as implemented by federal regulations and applicable state legislation, the Provider or Blue Cross may appeal such decision to an arbitrator assigned from the Appeals Panel, except that no appeal shall be permitted from a decision of the RRC in which an arbitrator has participated. Any decision by the Agency as to functions performed pursuant to the mandate of federal law, as implemented by federal regulations and applicable state law, shall be final and binding upon Provider and Blue Cross except to the extent appeals are available pursuant to such federal or state regulations and law.

19.6. *Financing.* Provider agrees to pay the cost of the work performed by the Agency pursuant to this Section 19 which is not provided to the Agency by other sources (including governmental funding) and Blue Cross agrees that this expense shall be included in the Provider's total allowable cost in the amount incurred for each fiscal year, or part thereof. The method of payment and calculation of cost shall be as described in the master agreement with the Agency or as prescribed by the RRC.

19.6.1. *Reimbursement by Blue Cross.* In calculating Blue Cross reimbursement, the Provider shall include its share of the total cost of the services to be performed by the Reviewing Agency pursuant to this Section 19 in its administrative cost using an approved method of cost finding in accordance with subsection 2.3 of Exhibit A,

Part I, and allocated in accordance with the approved method pursuant to subsection 2.2 of Exhibit A, Part I. In recognition of the potential benefits to be derived from this program in the containment of health care costs which will inure to subscribers, as well as to the community at large, Blue Cross agrees to assist the Provider in recovering that portion of this cost applicable to non-paying patients as follows:

Blue Cross shall make an unrestricted grant annually at the time of final settlement, separate and part from any other reimbursement required by this Agreement, in an amount equal to 100% of that portion of the Provider's cost attributable to the planning function performed by the Agency pursuant to this Section 19 which is applicable to the free care losses, excluding courtesy discounts ("free work"), for which no reimbursement would otherwise be received. The calculation of the amount of this grant shall be made in the following manner:

> Calculate the percentage that the free work charges are to the total gross charges for the fiscal year and then multiply the Agency's expense attributable to this Section 19 by that percentage. The resulting sum would then be attributable to free work, which expense will be reimbursed by Blue Cross in addition to that portion calculated to be payable by the Ratio of Charges to Charges Applied to Cost (R.C.C.A.C.) apportionment (this is a method of apportionment of each revenue producing department's cost on the basis of the ratio of Subscriber's Covered Services charges to total patient charges applicable to costs) of Blue Cross liability for Covered Services rendered to Subscribers.

The amount of this unrestricted grant is not to be included in the calculation of any "Retroactive Adjustment" as provided in subpart 2.4.4 of Exhibit A, Part I.

19.7. *Availability of Documents.* The Provider and Blue Cross shall make available to the Agency and its staff such documents, cost projections, prior planning agency reports and worksheets, files and other pertinent material as the Agency may reasonably request in order to accomplish the reviews described in this Section 19.

19.8. *Prior Planning Agency Determinations.* Determinations made by the designated Planning Agency pursuant to Section 24 of the 1971 Hospital Agreement, as modified by the 1973 Summary of Principles, prior to June 30, 1974, shall continue in full force and effect, but:

> (a) Any determination made after that date, but prior to July 1, 1976, shall not be used by Blue Cross as the basis for denying or reducing a Provider's reimbursement after the effective date of this Agreement; and
>
> (b) Either Blue Cross or the Provider may request a redetermination by the Agency designated pursuant to Section 19 of any determination made during the period July 1, 1974 to June 30, 1976, inclusive which requires future affirmative action by the Provider.

The RRC shall determine if this subsection applies to any Provider or set of circumstances upon appropriate application by Blue Cross or the Provider.

Section 20. Right of Appeal.

20.1. Appeals Panel.

Any disagreement between the parties hereto concerning this Agreement or its application, operation or interpretation, [except as to decisions made by the RRC which shall be final, binding and nonappealable], shall be referred to a disinterested arbitrator assigned by the RRC

from a list of arbitrators jointly selected by counsel for Blue Cross and the Delaware Valley Hospital Council (DVHC) on behalf of the Providers contracting hereunder prior to the date this Agreement is approved by the Pennsylvania Insurance Department. Subsequent additions or deletions from this list will be made only upon unanimous approval of the RRC. Assignment of the arbitrator by the RRC shall be made seriatim from the list in accordance with the sequence established by counsel at the time the list is initially presented to the RRC.

20.2. Procedure.

The arbitrator assigned to hear any matter shall conduct a formal hearing in conformance with the rules and regulations applicable to Commercial Arbitration as published by the Amercian Arbitration Association. Within thirty days following the conclusion of the hearing, the arbitrator shall forward his adjudication to the Provider and Blue Cross. The adjudication shall be in writing and signed by the arbitrator, and shall be final, binding and nonappealable.

20.3. Appeal Process Exclusive.

The appeal procedure described herein is the exclusive means for determining all disputes and disagreements as to this Agreement and its application, operation or interpretation, and no action at law or in equity shall be maintainable by either party to this Agreement against the other with respect to this Agreement, its application, operation or interpretation. Further, no appeal under this Section shall be maintainable unless brought within 2 years of the date the cause of action first arose. An appeal shall be deemed commenced when written notice of an appeal is delivered to the RRC and the other party hereto.

20.4. Costs of Appeal.

The costs associated with the foregoing appeals procedure shall be borne equally by the parties thereto and the Provider's share of such costs shall be included as a reimbursable cost hereunder.

Section 21. Term of Agreement.

21.1. This Agreement shall commence on July 1, 1976 and expire on June 30, 1978, provided however, that if Act 94 of 1975 is no longer applicable to the termination of this Agreement it shall be automatically extended through June 30, 1979. This Agreement shall supersede all previous agreements between the parties hereto, although it is expressly agreed that the 1971 Hospital Agreement (exclusive of subsection 18.4.6 therein and the 1972 amendment thereto), as modified by the 1973 Summary of Principles agreement between the parties hereto, shall apply to all admissions during the period July 1, 1974 to June 30, 1976, inclusive, and during the term of this Agreement, no limitations on total allowable costs as expressed in superseded agreements shall be applied for fiscal years commencing on or after July 1, 1974.

21.2. In making final settlement for fiscal years 1975 and 1976, all indemnity payments made by Blue Cross to Subscribers on account of Covered Services furnished by the Provider during the period the Provider was a "Nonmember Hospital," as defined in their respective Subscription Agreements shall be deducted from allowable cost hereunder. Each payment made by a Subscriber to the Provider during this period which was in excess of cost shall be retained by Provider and shall not be applied by Blue Cross to reduce reimbursement hereunder.

21.3. In the event this Agreement terminates as provided heretofore, any depreciation allowed as a result of a subsequent contract between Blue Cross and the Provider shall be calculated using the asset basis and method required by Exhibit A, Part I.

Section 22. Obligations After Termination.

In the event this Agreement terminates for any of the reasons set forth herein the Provider, if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the time of their admission to the Provider, and who were inpatients on the date of such termination.

Section 23. Medical Staff Privileges.

The Provider agrees to maintain the standards for staff appointment established by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Section 24. Budgetary Review Procedures.

24.1. *Reimbursement Review Committee.* To ensure that the reimbursement hereunder is established in a fair and equitable manner, a Reimbursement Review Committee (hereinafter called "RRC"), shall be formed to review the submitted budgets and subsequent reports of all contracting Providers and shall establish interim rates thereof. The RRC will be responsible for review, interpretation and application of any Principles set forth in Exhibit A Principles of Reimbursement as requested by either Provider or Blue Cross. The RRC shall consist of four members and a quorum of four members or their alternates is required for any action. The Delaware Valley

Hospital Council (DVHC) and Blue Cross shall each appoint two regular members and such voting alternates as the DVHC and Blue Cross may from time to time designate. All actions of the RRC shall require an affirmative vote of three to pass. Notice of all matters to be considered at any meeting of the RRC must be provided at least three business days prior unless waived by the RRC membership. Further, the RRC may adopt such rules and procedures as it shall determine are necessary to carry out its duties and responsibilities hereto.

24.2. *Submission and Review of Budget.* Each Provider shall submit its annual budget to the RRC not later than the May 15th prior to the beginning of each fiscal year on the standard form attached hereto as Exhibit B, which may from time to time be modified by the RRC as prescribed by the RRC. The budget as submitted shall have the prior approval of the Provider's governing board or its financial committee charged with the responsibility of preparing such material. The budget shall also contain an explanation of any unusual factors affecting the Provider's cost, such as, but not limited to, changes in patient mix, volume and new or reduced services. The RRC shall review the data submitted by Provider in accordance with the provisions of Exhibit A utilizing the following procedures:

24.2.1. If the RRC shall determine that the budget is reasonable and correct, it shall so advise the Provider and Blue Cross utilizing the gross inpatient per diem rate proposed by the Provider in its budget as the basis for interim reimbursement for patient days during such budgeted fiscal year.

24.2.2. If the RRC questions the reasonableness of the interim rate proposed in the budget, the RRC shall, within 30 days of receipt of the budget, so advise Pro-

vider and request additional data and a meeting with the Provider's representatives, as indicated. The RRC shall promptly forward a report of the interim rates it has found reasonable to Blue Cross.

24.2.3. If the RRC is unable to reach a majority decision as to the interim rate, it shall be joined by an arbitrator from the Appeals Panel and a decision made which shall be final and binding on both the Provider and Blue Cross. In the event of any such disagreement, and until a final decision is rendered, the interim rate to be paid by Blue Cross shall be the rate indicated in the submitted budget, unless the Provider advises Blue Cross it desires a lower rate be used for interim reimbursement. Following entry of a decision, the interim rate will be adjusted retroactively and any overpayment or underpayment, together with interest thereon at an annualized rate of one and one quarter percent above the prime commercial rate charged by the Philadelphia National Bank during such period, shall be paid or refunded by Blue Cross or Provider as appropriate.

24.3. Adjustments to Interim Rate.

24.3.1. The interim rate established by the RRC shall be subject to review and adjustment upon application of the Provider or Blue Cross. Changes in the interim rate may thereafter be applied retroactively by the RRC.

24.3.2. Provider shall submit quarterly to the RRC its statement of current operating costs within seven working days following the date when such is reviewed by its governing board or financial committee. The statement as submitted to the RRC shall show the actual operating expense of the Provider with budget comparisons for such period.

24.3.3. When the gross inpatient interim per diem rate has been established utilizing unaudited data, such rate shall be subject to appropriate increase or decrease retroactively and prospectively if the net audit adjustment, excluding nonrecurring items, amounts in aggregate to more than $1.00 per patient day.

24.4. *RRC Costs.* The operational costs of the RRC, except those applicable to Section 19 hereof, shall be borne equally by Blue Cross and those Providers contracting with Blue Cross under agreements which include provisions for a RRC. Further, those Providers shall pay the salaries and expenses of their designated representatives on the RRC, as well as any other compensation or benefits furnished such individuals, which costs will be recognized as a reimbursable cost hereunder. Similarly, Blue Cross will pay the costs associated with the salaries and expenses of its representatives on the RRC.

24.5. *Prospective Rating.* Provider may elect in lieu of reimbursement otherwise payable by Blue Cross under this Agreement to negotiate a fixed gross inpatient per diem rate or an aggregate annual rate of reimbursement (herein the "Prospective Rate") which shall be payable by Blue Cross in appropriate increments no less frequently than semi-monthly. Any Prospective Rate shall be determined to the mutual satisfaction of the parties based upon the Provider's approved budget. If during the prospective year there is a change in the arrangements described in Section 9 hereof, an appropriate concurrent change in the Prospective Rate shall be made. Moreover, it is agreed that such rate shall not be subject to review or appeal pursuant to Section 20 hereof. And the Provider will be permitted to retain for improvement of services all overage received by achieving a cost which

is below the Prospective Rate or be required to absorb any deficiency if during the appropriate final period its cost should exceed payments received under the negotiated Prospective Rate. Any grants, other than mere reimbursement or expenses incurred, to be paid Provider by Blue Cross pursuant to this Agreement shall be separate and apart from the amounts to be paid pursuant to this Subsection 24.5.

24.6. Additional RRC Responsibilities.

24.6.1. The RRC shall establish guidelines which Blue Cross shall utilize in approving all applications seeking the establishment of a Provider Outpatient Utilization Review Program which would qualify for grant payments by Blue Cross.

24.6.2. The RRC shall review the guidelines for Short Procedure Units which are contained in Section 25 and may from time to time recommend changes to those guidelines.

24.6.3. The RRC will undertake the various areawide planning functions described in Section 19 hereof.

Section 25. Short Procedure Units.

The Provider may apply to Blue Cross at any time during the term of this Agreement for certification of a Short Procedure Unit ("SPU"). In the event an SPU is so certified, reimbursement shall be made on the basis of reasonable cost. Routine service charges in the SPU may not exceed the Provider's daily service charge for the most prevalent semi-private accommodations for one day.

25.1. *Certification as a Short Procedure Unit.* The guidelines which shall be utilized in determining if Provider's SPU may be certified by the Plan are:

25.1.1. The Short Procedure Unit must be an identifiable function established by the Provider for the performance of therapeutic and diagnostic procedures that (i) cannot safely or appropriately be accomplished on a conventional outpatient basis, (ii) are best done in a hospital setting, and (iii) are usually completed within an eight-hour period without requiring an overnight stay in the hospital. Exceptions to the foregoing eight-hour limit may be made when justified.

25.1.2. The procedures to be performed in the SPU are usually those that can be scheduled in advance by the attending physician, but after which the patient cannot be discharged without a limited period of post-procedure observation.

The SPU will maintain a list of approved therapeutic and diagnostic procedures to be performed in the SPU. This list is open to permit additional procedures to be added as the need is identified. Some examples of the procedures which are customarily performed in the SPU and would be approved for reimbursement by Blue Cross are:

Certain multiple x-ray studies

Endoscopic procedures

D&C's and D&E's

Transfusions

Certain chemotherapeutic procedures

Angiograms

A wide range of minor surgical procedures, especially those requiring general anesthesia and observation of the patient for a period of time following the procedure.

25.1.3. The volume of procedures necessary to justify an SPU should require a minimum of four-designated

beds for post-procedure recovery (which may be used for other purposes in the event of insufficient SPU procedures) and appropriate staffing.

25.1.4. The SPU should include professional and administrative control and supervision to assure appropriate utilization so that patients are not admitted who could be appropriately cared for on a conventional outpatient basis.

25.2. Subscriber Benefits.

Blue Cross will provide benefits to Subscribers for approved procedures in a certified SPU as if they were inpatients.

25.3. Medical Staff and Patient Information.

Appropriate material shall be developed by the Provider for the information of its medical staff concerning utilization and scheduling as well as brochures for distribution to patients who will be cared for in the unit.

25.4. Review.

The RRC shall from time to time review the utilization review standards and qualifications for certification that an SPU shall satisfy as a prerequisite to continued grant payments pursuant to Section 3.

Section 26. Use of Modern Management Techniques.

26.1. The Provider may during the term of this Agreement undertake a comprehensive study of its operating or administrative procedures utilizing one or more independent consulting agencies to assure an optimal organization structure and fix staffing levels for each of its departments, using objectives acceptable to both the Provider and Blue Cross. Further, it is agreed that any such study may be undertaken with other hospitals on a

joint basis, and if the Provider has commenced or is continuing any such study, said study will satisfy the terms of this Section for the periods subsequent to July 1, 1976 if it has received the approval of Blue Cross. The cost of any such study shall be included in the operating costs of the Provider which are reimbursable in accordance with this Agreement for the applicable fiscal year in which payments are made.

26.2. If the study described in subsection 26.1 above is initiated by Provider, or other general or special management studies are undertaken which are determined by Blue Cross to be consistent with this Agreement, and if initial implementation of the recommendations produced by such study is commenced within six months immediately following the date of such recommendations, Blue Cross will make an unrestricted grant separate and apart from any other reimbursement required by this Agreement, based on the total cost of such study up to $100 per bed annually ($300 per bed annually in the case of general management studies). The foregoing grant shall be in a sum equal to the amount obtained by determining the maximum allowable per diem cost of the study applicable to all inpatient days during such fiscal year which have been provided to other than free and part-pay patients and multiplying such allowable per diem cost by the number of Blue Cross inpatient days provided during the applicable fiscal period.

26.3. In order to ensure that the recommendations of the foregoing studies are available for use by other health care institutions seeking to develop cost-saving programs, the Provider shall furnish to Blue Cross and the RRC on a scheduled basis a summary of all reports and relevant data regarding the results and implementation of its studies so that such information may be periodically distributed to other area hospitals.

Section 27. Section Headings.

The section headings used herein have been inserted for convenience of reference only and shall not in any way modify or restrict any of the terms or provisions hereof.

IN WITNESS WHEREOF, the parties hereto have caused these presents to be executed by their proper officers as of the date of execution set forth below.

Date of
Execution

_____ _____
Name of Provider

Effective Date

_____ By _____
Signature

_____
Title of Signing Officer

BLUE CROSS OF GREATER
PHILADELPHIA

_____
President

EXHIBIT A

PRINCIPLES OF REIMBURSEMENT

For purposes of establishing the amounts to be paid Provider by Blue Cross pursuant to this Agreement, Provider shall have the option during the term of this Agreement of being reimbursed on the basis of either "Reasonable Cost" or a "Prospective Rate", as such are more fully described hereinafter. The Provider must advise Blue Cross in writing which method it has elected prior to the end of the second month of each prospective fiscal year. This election once made by Provider may not be changed for such fiscal year. In the event Provider fails to make an election within the prescribed period, or is unable to reach agreement with Blue Cross on a Prospective Rate, the reimbursement to be paid Provider shall be calculated on the basis of "Reasonable Cost" as described in Part I of this Exhibit A.

PART I. REASONABLE COST BASIS

It is the intention of the parties hereto that application of the Principles set forth in Sections 1 and 2 hereof shall be made utilizing all current and future applicable Medicare interpretations, instructions and manuals containing informational and procedural matter as regards the various determinations of cost under these Principles, as promulgated by the Social Security Administration, Bureau of Health Insurance, or their successors, except where the Principles would make such material inappropriate.

No amendment to the Medicare Law, nor change in the sections of the Medicare Regulations captioned "Principle", as promulgated on July 1, 1967 shall be applicable to this Agreement.

Exhibit C

Section 1. PRINCIPLES TO BE USED IN DETERMINING SPECIFIC REIMBURSABLE COSTS.

1.1. Allowance for Depreciation Based on Asset Costs. (Sec. 405.415)

Principle

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation to be allowed under this Agreement must be:

(a) Identifiable and recorded in the Provider's accounting records from the date of acquisition, or appraisal if not recorded upon acquisition;

(b) Based on the historical cost of the asset (including assets financed with Hill-Burton or other federal or public funds) or fair market value at the time of donation in the case of donated assets; and

(c) Prorated over the remaining estimated useful life of the asset as in use as of July 1, 1971, using the straight-line method and based on the remaining undepreciated value, if any, as of July 1, 1971, with respect to depreciation taken for Blue Cross purposes under previous contracts between the Provider and Blue Cross.

1.1.1. Definitions.

(a) "Historical cost" is the cost incurred by the present owner in acquiring the asset.

(b) "Fair market value" is the price which the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.

Exhibit C

(c) Under the straight-line method of depreciation the cost or other basis (e.g. fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is first determined. This sum is then distributed equally over the estimated useful life of the asset.

1.1.2. Recording of Depreciation.

Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, historical cost, estimated useful life, and accumulated depreciation for Blue Cross purposes. The "Chart of Accounts" published by the American Hospital Association shall be employed as a guide in determining the estimated useful lives of assets.

1.1.3. Funding of Depreciation.

Although funding of depreciation is not required, it is strongly recommended that Providers use this mechanism as a means of conserving funds for replacement of depreciable assets. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

1.1.4. Gains and Losses on the Disposal of Depreciable Assets.

Gains and losses realized from the disposal of depreciable assets are to be included when computing allowable costs. If the gains or losses on the disposal of depreciable assets in a given fiscal year are greater than 10% of the total allowable depreciation for that period, the amount of gain or loss in excess of 10% must be carried forward over the next five succeeding years. Proper books of account identifying the gain or loss carry-forward for each

individual year must be separately maintained by Provider and any such carry-forward shall be considered first in determining the 10% limitation for any year.

The amount of gains and losses which are includable in allowable costs shall be calculated as follows:

(a) When an asset which was acquired by Provider before the date it entered into a "cost-type contract" with Blue Cross (hereinafter called the "Entry Date") is disposed of, a correction of prior years' depreciation based on actual life must be made before determining any gain or loss. The depreciation accumulated before the Entry Date must be corrected in the same manner as when making a new estimate of the asset's useful life. The gain or loss is the difference between the amount received for the asset and the corrected undepreciated cost at time of sale.

(b) Gain or loss on the disposal of assets acquired after the Entry Date is the difference between the sale price of the asset and the asset's unrecovered cost.

1.1.5. Establishment of Cost Basis on Purchase of Facility as Ongoing Operation.

In establishing the cost basis for a facility purchased as an ongoing operation after July 1, 1971, the price paid by the purchaser shall be the cost basis where it can be demonstrated that the transaction was a bona fide sale and the price paid did not exceed the fair market value of the facility at the time of sale. If a transaction is demonstrated to be other than a bona fide sale, the cost basis for depreciation purposes pursuant to this Agreement shall not exceed the undepreciated value calculated for Blue Cross purposes of such assets at the time of sale.

1.2. Interest Expense. (Sec. 405.419)

Principle

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

1.2.1. Definitions.

(a) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term which is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(b) Necessary requires that the interest be:

(i) incurred on a loan made to satisfy a financial need of the Provider as loans which result in excess funds or investments shall not be considered necessary;

(ii) incurred on a loan for a purpose reasonably related to patient care; and,

(iii) reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from the Provider's qualified pension fund or funded depreciation shall not be used to reduce interest expense.

(c) Proper requires that interest be:

(i) incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made; or

(ii) paid to a lender not related through control, ownership or personal relationship to the borrowing organization; however, interest is allowable if paid on loans from the Provider's donor-restricted funds, funded depreciation account or qualified pension fund.

1.2.2. Borrower-Lender Relationship.

(a) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan and thus be suggestive of an agreement on higher rates, interest or unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the Provider to related organizations is not allowable.

(b) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to the Provider by related organizations made prior to July 1, 1966 is an allowable cost, provided, the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where the general fund of a Provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, the interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the Provider's qualified pension fund, funded depreciation account, or funds borrowed

from the religious order responsible for the operation of the Provider.

(c) Where funded depreciation is used for purposes other than improvement replacement or expansion of facilities or equipment related to patient care, the allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in Provider's qualified pension fund when such are used for purposes other than that for which the fund was established.

(d) The allowable interest expense on the current indebtedness of the Provider will be adjusted to reflect the extent to which working capital needs attributable to Covered Services for Subscribers have been met by Blue Cross payments designed to provide reimbursement for services currently furnished to Subscribers. Any interest paid by the Provider to Blue Cross pursuant to subsection 24.2.3 of this Agreement shall not be a reimbursable cost hereunder.

1.3. Bad Debts, Charity, and Courtesy Allowances. (Sec. 405.420)

Principle

Bad debts, charity and courtesy allowances are deductions from revenue which are not to be included in allowable cost; however, bad debts attributable to Subscriber deductibles and coinsurance amounts are reimbursable hereunder.

1.3.1. Definitions.

(a) "Bad debts" are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing Covered Services. "Accounts receivable" and "notes receivable" are designations

for claims arising from the rendering of services and are collectible in money in the relatively near future.

(b) "Charity allowances" are reductions in charges made by the Provider because of the indigence or medical indigence of the patient.

(c) "Courtesy allowances" are reductions in charges in the form of an allowance to physicians, clergy, members of religious orders and others as approved by the governing body of the Provider for services received from the Provider. Employee fringe benefits, such as hospitalization and personal health programs, are not considered to be courtesy allowances.

1.3.2. Normal Accounting Treatment, Reduction in Revenue.

Bad debts, charity and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing services. Such costs have already been incurred in the production of the services.

1.3.3. Requirements of this Agreement.

Under this Agreement the cost of Covered Services furnished Subscribers is not to be borne by individuals not covered by Blue Cross, and conversely, the cost of services provided for other than Subscribers is not to be borne by Blue Cross. Uncollected revenue related to services rendered to Subscribers generally means the Provider has not recovered the cost of services covered by that revenue. The failure of Subscribers to pay the deductible and coinsurance amounts can result in the related costs of Covered Services being borne by other than Subscribers. The costs attributable to deductibles and coinsurance amounts, which remain unpaid, are to be added to the Blue Cross share of allowable costs. Bad debts arising from other sources are not allowable costs.

1.3.4. Criteria for Allowable Bad Debts.

A bad debt must meet the following criteria to be allowable:

(a) The debt must be related to Covered Services and derived from deductible and coinsurance amounts;

(b) The Provider must be able to establish that reasonable collection efforts were made;

(c) The debt was actually uncollectible when claimed as worthless; and

(d) Sound business judgment established that there was no likelihood of a future recovery.

1.3.5. Charging of Bad Debts and Bad Debt Recoveries.

The amounts uncollectible from specific Subscribers are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to Blue Cross may be recovered in a subsequent accounting period, in which event the income therefrom must be used to reduce the cost of Subscriber Covered Services for the period in which the collection is made.

1.3.6. Charity Allowances.

Charity allowances have no relationship to Subscribers and are not allowable costs. The cost to the Provider of employee fringe-benefit programs is an allowable element of reimbursement.

1.4. Cost of Educational Activities. (Sec. 405.421)

Principle

An appropriate part of the net cost of approved educational activities is an allowable cost.

1.4.1. Definitions.

(a) Approved educational activities mean formally organized or planned programs of study usually engaged in by the Provider in order to enhance the quality of patient care at an institution. These activities must be licensed where required by state law. Where licensing is not required, the institution must receive approval from the recognized national or state professional organizations for the particular activity.

(b) Net cost means the cost of approved educational activities (including stipends of trainees, compensation of teachers and other costs) less any reimbursement from grants, tuition, fellowships and other specific donations.

(c) Appropriate part means the net cost of the approved activity apportioned in accordance with the method set forth in this Exhibit A, Part I.

1.4.2. Educational Activities.

Many Providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community, however, many communities have not assumed responsibility for financing

these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, Blue Cross will participate appropriately in the support of these activities. Although the intent of Blue Cross is to share in the support of educational activities customarily or traditionally carried on by Providers in conjunction with their operations, it is not intended that Blue Cross should participate in increased costs resulting from distribution, transfer or redistribution of costs from educational institutions or units.

1.4.3. "Orientation" and "On-the-Job Training."

The cost of orientation and on-the-job training are not within the scope of this subsection but are recognized as normal operating costs in accordance with the subsections relating thereto.

1.4.4. Approved Programs.

In addition to approved medical, osteopathic, and dental internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by Provider institutions, and their approving bodies, include the following:

Program	*Approving Organization*
(a) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(b) Dietetic interships	The American Dietetic Association.

Exhibit C

Program	*Approving Organization*
(c) Hospital administration residencies	Members of the Association of University Programs in Hospital Administration.
(d) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(e) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(f) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(g) Nurse anesthetists	The American Association of Nurse Anesthetists.
(h) Professional nursing	Approved by the respective state authorities; reported for the United States by the National League for Nursing.
(i) Practical nursing	Approved by the respective state authorities; reported for the United States by the National League for Nursing.

Exhibit C

(j) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(k) Pharmacy residencies	American Society of Hospital Pharmacists.
(l) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(m) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

1.4.5. Other Educational Programs.

There may also be other educational programs not included in the foregoing in which the Provider is engaged. Appropriate consideration will be given by Blue Cross to the costs incurred for those activities that come within the purview of this subsection when determining allowable costs for apportionment under this Agreement.

1.5. Research Costs. (Sec. 405.422)

Principle

Identifiable costs incurred directly or indirectly for research purposes which exceed normal costs of usual

patient care and are not otherwise reimbursed, shall be excluded from allowable cost.

Application

(a) There are numerous sources of financing for health-related activities. Funds for this purpose are provided under many federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs.

(b) To ensure that all identifiable costs associated either directly or indirectly with research are not included in computing reimbursable cost, Provider shall maintain detailed books of account and other records as are necessary to identify research costs.

(c) Normal and usual costs of patient care which are not reimbursed from other sources shall be included as an allowable cost when incurred directly or indirectly for research purposes.

1.6. Grants, Gifts and Income from Endowments. (Sec. 405.423)

Principle

Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.

1.6.1. Definitions.

(a) Unrestricted grants, gifts and income from endowments are funds, cash or otherwise, given to the Provider without restriction by the donor as to their use.

(b) Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise which must be used only for specific purposes designated by the donor, but does not refer to unrestricted grants, gifts or income from endowments which have been restricted for a specific purpose by the Provider.

1.6.2. Application.

(a) Unrestricted funds, cash or otherwise, are generally the property of the Provider to be used in any reasonable manner its management deems appropriate and should not be deducted from operating costs.

(b) Donor-restricted funds which are designated for paying certain operating expenses of the Provider should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the Provider would secure reimbursement for the same expense twice being reimbursed through donor-restricted contributions as well as from patient and third-party payers including Blue Cross.

1.7. Value of Services of Nonpaid Workers. (Sec. 405.424)

Principle

The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and the

Provider for the performance of such services without direct remuneration from the Provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in this subsection. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses and paid no later than the end of the Provider's fiscal year following the fiscal year during which the services were rendered.

1.7.1. Limitations; Services of Nonpaid Workers.

To be reimbursable, the services of nonpaid workers must be performed on a regularly scheduled basis in positions customarily held by full-time employees and be necessary to enable the Provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which Providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under this Agreement. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a Provider canteen, cafeteria or gift shop, would not be reimbursable.

1.7.2. Application.

The following illustrates how the Provider would determine an amount to be allowed under this subsection. The prevailing salary for a lay nurse working in hospital A is $12,000 a year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $5,000 and are included in the hospital's allowable operating costs. The hospital would then include in its

records an additional $7,000 to bring the value of the services rendered to $12,000. The amount of $7,000 would be allowable where the Provider assumes the obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by Provider for the services.

1.8. Purchase Discounts, Allowances and Refunds of Expenses. (Sec. 405.425)

Principle

Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

1.8.1. Definitions.

(a) Discounts are generally reductions granted for the settlement of debts.

(b) Allowances are deductions granted for damage, delay, shortage, imperfection or other causes, excluding discounts and returns.

(c) Refunds are amounts paid back or a credit allowed on account of an overcollection.

1.8.2. Normal Accounting Treatment: Reduction of Costs.

All discounts, allowances and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchase was made or expense incurred, they will reduce the cost of the purchase or expense of that period. However, when they are received in a later accounting period they will reduce the cost of a comparable purchases or expenses in the period in which they are received.

1.8.3. Application.

(a) Purchase discounts have been classified as cash, trade or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(b) As with discounts, allowances and rebates received from purchases of goods or services, refunds of previous expense payments are clearly reductions in cost and must be reflected in the determination of allowable costs. This treatment is equitable and in accord with that generally followed by governmental programs and other third-party organizations paying on the basis of cost.

1.9. Cost of Related Organizations. (Sec. 405.427)

Principle

Costs applicable to services, facilities and supplies furnished to the Provider by organizations related to the Provider by common ownership or control are includable in the allowable cost of the Provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere.

1.9.1. Definitions.

(a) Related to the Provider means that the Provider to a significant extent is associated or affiliated with, has

control of, or is controlled by the organization furnishing the services, facilities or supplies, provided, however, cooperative organizations sponsored by three or more Providers shall not be deemed "related to the Provider."

(b) Common ownership exists when an individual or individuals possess significant ownership or equity in the Provider and the institution or organization serving the Provider.

(c) Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

1.9.2. Application.

(a) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance and other ways.

(b) Where the Provider obtains services, facilities or supplies from an organization even though it is a separate legal entity, and the organization is owned or controlled by the owner of the Provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities or supplies is lower than the cost to the supplier, the allowable cost to the Provider shall not exceed the market price.

1.9.3. Exception.

An exception is provided to this general principle if the Provider demonstrates by convincing evidence to the satisfaction of the RRC that (i) the supplying organization is a bona fide separate organization; (ii) a substantial part of its business activity of the type carried on with the Provider is transacted with others than the Provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities or supplies furnished by the organization; (iii) the services, facilities or supplies are those which commonly are obtained by institutions such as the Provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and (iv) the charge to the Provider is in line with the charge for such services, facilities or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities or supplies. In such cases, the charge by the supplier to the Provider for such services, facilities or supplies shall be an allowable cost.

1.10. Allowance in Lieu of Specific Recognition of Other Costs.

In recognition of the difficulty of measuring all costs of Covered Services, Blue Cross shall pay annually to the Provider as part of its reimbursement hereunder an amount equal to one percent of the Provider's total allowable Blue Cross costs for the then current fiscal year. Payment to Provider shall be made not less frequently than quarterly, at the rate of one-quarter (¼) of the annual amount to be paid Provider with an appropriate adjustment being made at the time of final audit.

1.11. Allowance to Offset Free Care and Bad Debt Losses.

As an offset to the free care and bad debt losses (excluding courtesy discounts) incurred by Providers in furnishing hospital care, Blue Cross shall provide annually during the term of this Agreement, an aggregate annual amount for all Providers listed on Table I below, calculated by multiplying two percent of the listed Providers' total allowable Blue Cross costs, less depreciation and interest, by the ratio of the listed Providers' total allowable Blue Cross costs to total allowable Blue Cross costs, less depreciation and interest, for the then current fiscal year. This aggregate amount shall be allocated to each Provider as provided in Table I below, which has been developed after consideration of each Provider's free care and bad debts, and the resources available to the Provider from sources other than patient payments for such purposes. This allocation shall remain constant throughout the term of this Agreement.

The aggregate amount to be provided for each fiscal year shall initially be established on the basis of the Blue Cross portion of the approved budget costs, and adjusted in each subsequent fiscal year at the time of final settlement. Payment to each Provider shall be made not less frequently than monthly at the rate of 1/12th of the annual amount, with an appropriate adjustment being made at the time of final audit.

TABLE I

Hospitals	*Percent*
Abington	2.25
All Saints	—
Bryn Mawr	3.50

Exhibit C

Hospitals	*Percent*
Bryn Mawr Rehabilitation	—
Chestnut Hill	1.00
Crozer-Chester	11.48
Delaware County	2.71
Doylestown	1.44
Episcopal	6.88
Frankford	4.15
Germantown	4.03
Holy Redeemer	2.71
Jeanes	1.00
Lankenau	3.27
Magee	1.00
Memorial of Roxborough	1.38
Mercy Catholic	13.41
Methodist	5.04
Montgomery	1.76
Nazareth	3.55
Northeastern	3.14
Paoli	2.57
Phoenixville	1.68
Presbyterian	3.96
Riddle	1.06
Sacred Heart General	1.00
Sacred Heart (Norristown)	2.31
St. Christopher's	5.79
St. Joseph's	1.84
Suburban	1.94
Taylor	1.40
West Park	1.00
Wills Eye	1.75
	100.00

Exhibit C

1.12. Payment of Section 1.10 and 1.11 Allowances During Fiscal Year 1977.

The payments provided for in Sections 1.10 and 1.11 shall not become effective until September 1, 1976, but during the period from September 1, 1976 through June 30, 1977, these payments shall be calculated on the basis of a full fiscal year and paid at a quarterly rate equal to 1/3 of the annual amount in the case of the Section 1.10 allowance and at a monthly rate equal to 1/10 of the annual amount in the case of the Section 1.11 allowance, subject in each case to appropriate adjustment at the time of final audit.

Section 2. GENERAL PRINCIPLES OF REIMBURSEMENT.

2.1. Cost Related to Patient Care. (Sec. 405.451)

Principle

All payments to Providers of services must be based on the "reasonable cost" of services covered and related to the care of Subscribers except to Providers which charge on an overall hospital basis less than cost for Covered Services or which elect to be reimbursed for outpatient Covered Services under any of the options provided in subsection 2.4 of this Exhibit A, Part I. Reasonable cost includes all necessary and proper cost incurred in rendering the services, subject to principles relating to specific items of revenue and cost. Any Provider cost for Covered Services which would have been attributable to Part B of Medicare if the case had been covered under Medicare, shall be included.

Exhibit C

2.1.1. Definitions.

(a) The reasonable cost of services is defined as that cost which is allowable under this Agreement. The cost of any services must be determined in accordance with regulations establishing the method to be used and the items to be included. The regulations in this subsection take into account both direct and indirect costs of the Provider. The objective of this subsection is to ensure that reasonable costs associated with Subscriber Covered Services will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by Blue Cross. These regulations also provide for the making of suitable retroactive adjustments after the Provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the Provider during the year for Covered Services from both Blue Cross and Subscribers and the amount determined in accordance with an accepted method of cost apportionment to be the actual allowable cost of Covered Services rendered to Subscribers during such year.

(b) Necessary and proper costs are costs which are appropriate and allowable in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the Provider's activity.

(c) Allowable costs are those costs as determined hereunder subject to the limitation set forth in 2.1.2(d) below.

2.1.2. Application.

(a) It is the intent of this Agreement that payments to the Provider should be fair and equitable to both the Provider and Blue Cross.

Exhibit C

(b) The costs of Providers vary from one to another and the variations generally reflect differences in scope of services and intensity of care. The provision for payment of reasonable cost of Covered Services is intended to meet the actual costs, however widely they may vary from one institution to another.

(c) The determination of reasonable cost of Covered Services must be based on costs related to the care of patients. Reasonable cost includes all necessary and proper expenses incurred in rendering Covered Services, such as administrative costs, maintenance costs and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the Provider's operating costs include amounts not related to patient care, or specifically not reimbursable under the Subscription Agreement, such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the Provider will be reimbursed the actual costs of providing quality care however widely the actual costs may vary from Provider to Provider and from time to time for the same Provider.

(d) If Blue Cross wishes to reduce the final payment on the basis that Provider's costs are substantially out of line with the costs of other hospitals in the same area which are similar in size, scope of services, utilization and other relevant factors, or where such factors can be adjusted to meet the criteria of comparability, Blue Cross may appeal directly as provided in Section 20 for such authority, and in such cases Blue Cross shall have the burden of proof. All costs payable pursuant to Section 9 of the Agreement shall be considered in all comparisons made.

Exhibit C

2.2. Determination of Cost of Covered Services to Blue Cross Subscribers. (Sec. 405.452)

Principle

Total allowable costs of a Provider shall be apportioned between Blue Cross Subscribers and other patients so that the share borne by Blue Cross is based upon actual Covered Services received by Subscribers. To accomplish this apportionment, the Provider shall use the departmental method for cost determination unless an alternative method is approved by the Provider and Blue Cross.

2.2.1. Definitions.

(a) Under the departmental method, the ratio of Subscriber charges for Covered Services to total patient charges for the services of each department is applied to the cost of that department.

(b) "Apportionment" means an allocation or distribution of allowable cost between Subscribers and other patients.

(c) "Routine services" means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(d) "Ancillary services or special services" are the services for which charges are customarily made in addition to routine services.

(e) "Charges" refers to the regular rates for various services which are charged to both Subscribers and other patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services and such charges shall be the same for all classes of patients.

Exhibit C

(f) "Cost" refers to reasonable cost as described in subsection 2.1 hereof.

(g) The ratio of Subscriber charges for Covered Services to total charges on a departmental basis, as applied to inpatients, means the ratio of inpatient charges to Subscribers for Covered Services of a revenue-producing department or center to the inpatient charges of all patients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of Covered Services rendered to Subscribers is computed by applying the individual ratio for the center to the cost of the related center for the period.

2.2.2. Application.

(a) This Agreement provides that the costs of Covered Services with respect to individuals covered by Blue Cross will not be borne by individuals not so covered, and conversely, that costs with respect to individuals who are not covered by Blue Cross will not be borne by Blue Cross.

(b) The cost of inpatient Covered Services to Subscribers is to be determined by the Provider using the departmental method; the objective of which is to approximate as closely as practicable the actual cost of inpatient services rendered.

(c) Effective July 1, 1977, the cost of outpatient Covered Services to Subscribers shall be determined by the Provider using the departmental method; the objective of which is to approximate as closely as practicable the actual cost of outpatient services rendered.

(d) The method of apportionment for use in determining the cost of Covered Services rendered to Subscribers has as its goal the allocation of total allowable

costs between Subscribers and other patients in as equitable a manner as possible.

2.3 Adequate Cost Data and Cost Finding. (Sec. 405.453)

Principle

Providers receiving payment on the basis of reasonable cost must provide adequate cost data. This will be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding utilizing the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

2.3.1. Definitions.

(a) "Cost finding" is the process of recasting the data derived from the accounts ordinarily kept by a Provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(b) Under the "accrual basis of accounting" revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

2.3.2. Adequacy of Cost Information.

Adequate cost information must be obtained from the Provider's records to support payments made for services rendered to Subscribers. The requirement of adequacy of

data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts, and effective and efficient management of any organization. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

2.3.3. Uniform Accounting Procedures.

Implicit in providing adequate cost information is uniformity in reporting among all hospitals under this Agreement and therefore the Provider and Blue Cross shall comply with the instructions to be issued from time to time to accomplish this as agreed to by the RRC.

2.3.4. Inadequate Data.

If the Provider is unable to furnish adequate data, Blue Cross and the Provider or the RRC will make an appropriate estimate for use in support of payments to be made for Covered Services rendered to Subscribers.

2.3.5. Cost Finding Methods.

After the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual cost of services rendered during that period.

(a) *Step-down method.* This method recognizes that services rendered by certain nonrevenue-producing de-

partments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some services from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(b) *Other methods*—(i) *Double-apportionment method.* The double-apportionment method may be used by the Provider upon approval of Blue Cross or the RRC. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as the revenue-producing centers. A preliminary allocation of the costs of the nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing centers directly to the revenue-producing centers. However, having elected to

use the double-apportionment method, the Provider may not thereafter use the step-down method without approval of Blue Cross or the RRC.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the Provider upon approval of Blue Cross or the RRC. Request for the approval of such methods must be made on a prospective basis and submitted before the end of the first quarter of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the Provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

2.4. Payments to Providers. (Sec. 405.454)

Principle

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers. Interim payments approximating the actual cost of the Provider will be made on the most expeditious basis administratively feasible. A retroactive adjustment based on actual costs will be made at the end of the reporting period and an appropriate payment made by either Blue Cross or the Provider to correct any overpayment or underpayment. At the request of Provider, payment will be made on the basis designed to reimburse currently for Covered Services rendered to Subscribers.

2.4.1. Amount and Frequency of Payment.

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers. Since actual costs of Covered Services cannot be determined until the end of the accounting period, the Provider must be paid on an estimated cost basis during the year. Interim pay-

ments shall be made no less often than semi-monthly on the most expeditious basis administratively feasible. The estimated cost basis for determining interim payments during the year shall be based on one hundred percent of the Provider's budget submitted in accordance with Section 24 of this Agreement, as approved by the RRC, so that the retroactive adjustment based on actual costs will be as small as possible.

2.4.2. Interim Payments.

(a) The gross interim inpatient per diem rates of payment will be determined based on the Provider's budget as submitted and approved in accordance with Section 24 of the Agreement. This interim rate of payment may be adjusted by the RRC during the applicable accounting period if the Provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the RRC may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(b) Outpatient interim rates, including the SPU, will be a percentage of charges based on outpatient costs and charges information of the Provider and calculated using the Provider's budget as submitted and approved in accordance with Section 24 of the Agreement, or the latest submitted cost report.

2.4.3. Determination of Interim Payments to Providers.

Inpatient interim payments will be determined using the gross inpatient per diem cost multiplied by the number of days of Covered Services, less any co-payment or deductible.

Example: On a six day stay under the Co-Pay Comprehensive Subscription Agreement with the following, arbitrarily chosen amounts, the remittance would be calculated as follows:

Gross Per Diem Cost	$ 60.00
Multiplied by:	
Blue Cross Covered Service Days	×6
	$360.00
Less:	
Co-Payment: 6 days at $5.00 per day	30.00
Remittance to Provider	$330.00

2.4.4. Retroactive Adjustment.

(a) At the end of a quarterly reporting period, a retroactive adjustment will be made to bring the interim payments made to the Provider during the period into agreement with the reimbursable amount payable to the Provider for the Covered Services rendered to Subscribers during that period.

(b) In order to reimburse the Provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received and the desk review completed. For this purpose, the cost report will be accepted as filed unless there are obvious errors or inconsistencies—subject to later audit. Any dispute will be resolved by the RRC. The amount determined as a result of the desk review shall be payable in full within twenty days following such review to either the Provider or Blue Cross, as appropriate. When a final audit is made and the Providers allowable cost hereunder is determined, a final payment will be made by either the Provider or Blue Cross, as appropriate.

(c) To determine the retroactive adjustment, the amount of the Provider's total allowable reasonable cost

apportioned to Blue Cross for the reporting year is computed. This is the total amount of cost reimbursement the Provider is due to receive from Blue Cross and Subscribers for Covered Services rendered during the reporting period. The total of the interim payments made by Blue Cross in the reporting year and the deductibles and coinsurance amounts receivable from Subscribers is next computed. The difference between the reimbursement due and the sum of payments made by Blue Cross and amounts payable by Subscribers is the amount of the retroactive adjustment. Any dispute as to the amount of the Provider's total allowable reasonable cost shall be resolved by the RRC.

2.4.5. Providers which Charge Less in the Aggregate than Total Payments received from Blue Cross under this Agreement.

Payments to a Provider which on an overall hospital basis charge less in the aggregate for inpatient Covered Services than the total payments received from Blue Cross pursuant to this Agreement for inpatient Covered Services will be reimbursed based on charges and related to the percentage of total Blue Cross inpatient days in such institutions in the following manner:

If less than ten percent of the total Blue Cross inpatient days occur in hospitals which charge less in the aggregate than the total payments received from Blue Cross pursuant to this Agrement, payment to such Providers shall be one hundred percent of charges for Covered Services. For each five percent increase in the percentage of total Blue Cross inpatient days which occur in hospitals which charge less in the aggregate than the total payments received from Blue Cross pursuant to this Agreement, in excess of the first ten percent, the percent of charges paid to such hosiptals shall be decreased one

percent. The payment to such hospitals, however, shall never be less than ninety-five percent of charges.

2.4.6. Provision for Current Reimbursement.

Based on the premise that (i) payment for Subscriber Covered Services should be constructively received by the Provider as promptly as possible following the patient's discharge and (ii) it is a reasonable expectation that the Provider will promptly complete and submit Subscriber bills within seven days after discharge and Blue Cross will process such bills within six days after receipt, with an allowance of two days for mail deliveries, or a total of fifteen days, Blue Cross shall make available the following programs:

(a) In addition to the basic procedure for reimbursement, Blue Cross will, upon request by the Provider, make an advance payment in an amount equal to the sum of the following:

(i) The number of Subscriber inpatient discharges during an average fifteen day period multiplied by the Provider's projected average Blue Cross payment per case based on the approved budgeted data and actual experience in the most recent available fiscal year;

(ii) Average daily outpatient payments to the Provider by Blue Cross in the most recent available fiscal year, multiplied by fifteen; and,

(iii) Average daily maternity, nursery and Medicare supplementary indemnity payments to the Provider by Blue Cross in the most recent available fiscal year, multiplied by fifteen.

The above calculation will be updated by Blue Cross upon receipt from the Provider of the current data required by Section 24 of the Agreement. In the event any

advances currently outstanding differ from the amount determined by such recalculation, Blue Cross will appropriately increase or decrease the outstanding advance within ninety days thereafter.

(b) In the event the Provider is unable to promptly complete its billing procedure, the Provider may, at any time request, subject to Blue Cross approval, a supplementary advance equal to that provided in subsection (a) above. The Provider will pay to Blue Cross interest on the outstanding balance of any supplementary advance at the annualized rate of one and one quarter percent above the prime rate of interest charged by Philadelphia National Bank on the last working date of each month. Such interest shall be calculated monthly and deducted from succeeding daily remittances being considered interest paid for borrowed working capital. The supplementary advance shall be repaid by the Provider to Blue Cross on mutually acceptable terms, but in no event shall any supplementary advance, in whole or part, remain outstanding beyond the last day of the stated term of this Agreement.

(c) Blue Cross shall submit, upon request, any and all data the Provider may require to determine the allowable amounts hereunder.

(d) If the Provider has elected the optional Periodic Interim Payment method, described in subsection 2.4.7 below, it shall not be eligible for the advances permitted by this subsection.

2.4.7. Optional Periodic Interim Payment.

In lieu of the payment procedure described in subsection 2.4.6 above, Provider may elect the Periodic Interim Payment method of reimbursement (as described in current Medicare regulations as such may exist from time to time hereafter) if such election is made in writing

and delivered to Blue Cross within 15 days following the execution of this Agreement for the first fiscal year hereof, and in subsequent years at least 30 days prior to the beginning of the fiscal period. In the event such election is made all current reimbursement then outstanding shall be repaid to Blue Cross within 60 days following the date of such election, or as otherwise agreed by the Provider and Blue Cross.

2.4.8. Cost Reporting Period.

Blue Cross will require submission of reports of operations based upon the Provider's accounting year within 120 days of the close of the Provider's fiscal year, subject to the same late filing restrictions on subsequent reimbursement as are applicable for failure to file like reports under then Medicare regulations.

2.4.9. Reporting Budgeted Cost of Whole Blood.

Provider shall submit to Blue Cross and RRC upon request, or at the time of the annual budget submission, the annual cost budgeted by the Provider for whole blood.

PART II. PROSPECTIVE RATE BASIS.

If the Provider elects to be reimbursed on a prospective rate basis, it shall submit the material required for budgetary review as provided in Section 24 of the Agreement. Using this material and other data which it may request, Blue Cross and the Provider shall prospectively establish a fixed gross inpatient per diem rate or annual rate of reimbursement which shall be based on the principles set forth in Part I of this Exhibit A.

1. Inpatient Services.

The Provider shall be reimbursed for inpatient Covered Services provided to Subscribers based on the

prospective rate which shall be determined to the mutual satisfaction of Provider and Blue Cross in accordance with the terms and limitations set forth in Section 24 of this Agreement. In the event Provider is reimbursed for inpatient Covered Services in accordance with this Part II, those principles set forth in Part I of this Exhibit A which apply to reimbursement for inpatient services shall not alter or modify such fixed prospective rate, but in the case of gross inpatient per diem rates the computation of inpatient claims shall be made in the manner as provided in subsection 2.4.3 "Determination of Interim Payment to Providers" of Exhibit A, Part I, and such payments shall be final payment. No retroactive adjustment to such payments shall be made on the basis of actual cost except as otherwise provided in Section 24 of this Agreement.

2. Outpatient Services.

In determining the payments for outpatient services to be made to a Provider who has elected to be reimbursed on a prospective rate basis, payment will be made to the Provider pursuant to subsection 2.4 or on a prospective rate agreed to in advance by Blue Cross and the Provider. The foregoing election shall be binding upon the Provider for the fiscal year covered by such prospective rate, but may be changed when a new prospective rate is established for a subsequent fiscal year.

3. Other Requirements.

Providers electing to be reimbursed on the prospective rate basis shall be subject to all the provisions in this Agreement except where specifically stated otherwise in this Part II of this Exhibit A or elsewhere in this Agreement.

EXHIBIT B

OPERATING BUDGET

INSTRUCTIONS

Introduction

The budget forms were prepared by the Joint Blue Cross-Hospital Council Task Force on Budget Review.

The form and content includes the information necessary for conformity with the new Blue Cross "Hospital Agreement" under provision section 24 "Budgetary Review Procedure."

SECTION 24. *Budgetary Review Procedures.*

24.2. Submission and Review of Budget.

Each Provider shall submit its annual budget to the RRC not later than the May 15th prior to the beginning of each fiscal year on the standard form attached hereto as Exhibit B, which may from time to time be modified by the RRC as prescribed by the RRC. The budget as submitted shall have the prior approval of the Provider's governing board or its financial committee charged with the responsibility of preparing such material. The budget shall also contain an explanation of any unusual factors affecting the Provider's cost, such as, but not limited to, changes in patient mix, volume and new or reduced services. The RRC shall review the data submitted by Provider in accordance with the provisions of Exhibit A utilizing the following procedures:

24.2.1. If the RRC shall determine that the budget is reasonable and correct, it shall so advise the Provider and Blue Cross utilizing the gross inpatient per diem rate proposed by the Provider in its budget as the basis for interim reimbursement for patient days during such budgeted fiscal year.

24.2.2. If the RRC questions the reasonableness of the interim rate proposed in the budget, the RRC shall, within 30 days of receipt of the budget, so advise Provider and request additional data and a meeting with the Provider's representatives, as indicated. The RRC shall promptly forward a report of the interim rates it has found reasonable to Blue Cross.

24.2.3. If the RRC is unable to reach a majority decision as to the interim rate, it shall be joined by an arbitrator from the Appeals Panel and a decision made which shall be final and binding on both the Provider and Blue Cross. In the event of any such disagreement, and until a final decision is rendered, the interim rate to be paid by Blue Cross shall be the rate indicated in the submitted budget, unless the Provider advises Blue Cross it desires a lower rate be used for interim reimbursement. Following entry of a decision, the interim rate will be adjusted retroactively and any overpayment or underpayment, together with interest thereon, at an annualized rate of one and one quarter percent above the prime commercial rate charged by the Philadelphia National Bank during such period, shall be paid or refunded by Blue Cross or Provider as appropriate.

Statistical definitions shall conform to the A.H.A. "Uniform Hospital Definitions," dated 1960.

Providers are required to enter their name, Blue Cross Code Number and the applicable dates on each page in the spaces provided, also enter applicable dates in the headings, "Actual, Projected and Budget."

Budget Forms

A. Summary of Costs

B. Calculation of Tentative Blue Cross Gross Payment Rate

C. Departmental Summary and Per Diem Calculation

D. Statistics

E. Salaries & Wages-Employees & Fees

F. Supplies & Expenses

G. Depreciation Expense

H. Analysis of Recovery of Expense Items

I. Personnel Policies

J. Supplemental Questionnaire

K. Comparative Report Educational Expenses

Filing Date

Budget forms should be prepared and submitted no later than the May 15th prior to the beginning of the fiscal year.

Number of Copies Required

All forms should be completed and filed in *duplicate.* (Typing not required, but must be legible copy.)

Actual Expenses

Should represent actual expenses for the first complete preceding fiscal year.

Projected Expenses

Provider should indicate the number of months of actual expenses (minimum of six months) and the number of months of estimated expenses in the current fiscal year.

Instructions for Completing Budget Forms

Form A—Self-explanatory.

Form B—Self-explanatory.

Exhibit C

Form C—Departmental Summary and Per Diem Calculation:

(1) Detailed figures reported should be budgeted figures only.

(2) Amounts reported as Salaries & Wages-Employees & Fees, Supplies & Expenses and Depreciation should agree in total with the amounts reported on the budgeted detailed expense schedules (Forms E, F, and G).

(3) The per diem amounts should be based on the total budgeted patient days as reported on Form D.

(4) The paid hours should agree with the total of hours as reported on the detailed Form E.

(5) The requested operating statistics should be completed in accordance with the detailed notes on Form C, Page 5 and should be based on the amounts and hours as reported on Form C.

Form D—The regularly maintained number of beds represents the *average* number of beds available, set up and staffed for use during the applicable year.

Form E—Salaries & Wages-Employees & Fees:

(1) The number of full-time equivalent employees (FTE) should be determined by dividing the paid hours by 2080 annual hours per employee.
The number of salaried employees, and/or physicians on a fee basis for

Exhibit C

which paid hours are not recorded shall be included in the FTE, calculated by adding 2080 hours for each such full-time person and the part of 2080 hours represented by the percent of time spent in hospital activities for each such part-time person.

(2) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(3) The total amount on Page 7, Line 93 should be carried forward to Form A, Line 1.

Form F—Supplies & Expenses:

(1) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(2) The total amount on Page 7, Line 91 should be carried forward to Form A, Line 2.

(3) The total amount of interest expense on Page 7, Line 94 should be carried forward to Form A, Line 4.

Form G—Depreciation Expense:

(1) For Blue Cross purposes, only straight line method of depreciation is permitted.

(2) The total amount of depreciation on Form G, Line 9 should be carried forward to Form A, Line 3.

Exhibit C

Form H—Analysis of Recovery of Expense Items:

(1) The totals on Form H, Line 16 should be carried forward to Form A, Line 6.

Form I—Self-explanatory.

Form J—Self-explanatory.

Form K—Comparative Report Educational Expenses:

The purpose of this Form is to identify the amount of educational expense.

(1) Salaries and fees are the totals including those charged directly to the teaching program, to various cost centers, etc. Portions of salaries and fees paid to those individuals which are not related to intern and residence programs are to be excluded.

(2) Fringes and/or perquisites are those which are *not* furnished all other employees; e.g. value of living accommodations, meals, laundry, drugs, use of automobile, etc., but excluding malpractice insurance.

Exhibit C

FORM A

Date Submitted: _____

B. C. Code No. _____

OPERATING BUDGET
Summary of Costs

(HOSPITAL)

Fiscal Year: _____

	ACTUAL		PROJECTED		BUDGET		Percentage Variances	
TOTAL OPERATING EXPENSES	Amount	%	Amount	%	Amount	%	Projected to Actual	Budget to Projected
1. Salaries & Wages—Employees & Fees (From Form E, line 93)	$		$		$		%	%
2. Supplies & Expenses (From Form F, line 91)								
3. Depreciation (From Form G, line 9)								
4. Interest on Indebtedness (From Form F, line 94)								
5. TOTAL Expenses		100%		100%	$	100%		
Less Deductions and Recoveries								
6. Items of Income which are recovery of expenses (From Form H, line 24)								
7. Less: Research (From Form E, line 91 plus Form F, line 75)								
8. Less: Non-Reimbursable Functions (From Form E, line 92 plus Form F, line 76)								
9. Less: Home Care (From Form E, line 69 plus Form F, line 52)								
10. Less: Extended Care (From Form E, line 39 plus Form F, line 51)								
11. Less: Other: (Explain)								
12.								
13.								
14. TOTAL Deductions	$		$		$			
15. TOTAL Patient Care Expenses Net	$		$		$			

I certify that this Budget has been reviewed and approved by the governing body of this institution.

_____ (Date) _____ (Signature) _____ (Title)

Exhibit B

OPERATING BUDGET
Calculation of Tentative Blue Cross Gross Payment Rate

FORM B

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

92a

Fiscal Year: _____

	ACTUAL	PROJECTED	BUDGET	Percentage Variances: Projected to Actual	Percentage Variances: Budget to Projected
1. Total Patient Care Expenses Net (Form A, line 15)	$	$	$	%	%
2. Less: Out Patient Expenses (Note 1)					
3. Total In Patient Expense (Line 1 — line 2)					
4. Total In Patient Days (Excluding Newborn)					
5. TOTAL Average Per Diem In Patient Expenses (Line 3 ÷ line 4)	$	$	$		
	$	$	$		

Note 1 — Out Patient expenses to be calculated on the ratio of the provision: gross out patient expenses to total expenses per Blue Cross Cost Report Schedule C applied to Line 2 above.

Exhibit C

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(Form B)

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 1 of 5

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS: Salaries & Wages—Employees and Fees — Amount	Salaries & Wages—Employees and Fees — Per Diem	Supplies & Expenses (Forms F & G) — Amount	Supplies & Expenses (Forms F & G) — Per Diem	Budgeted Total Costs — Amount	Budgeted Total Costs — Per Diem	Paid Hours (Form E)	Operating Departmental Statistics
1. ADMINISTRATIVE AND GENERAL								
Executive offices	$	$	$	$	$	$		
Accounting & Fiscal								
All other Administrative Expenses								
TOTAL	$	$	$	$	$	$		
Direct Cost Per Bed (note 1)								
Manhours Per Bed (note 2)								
2. DIETARY								
Number of Meals Served								
Direct Cost Per Meal								
Meals Served Per Manhour								
3. PLANT								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								
4. HOUSEKEEPING								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								

Exhibit C

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(Form B)

93a

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 2 of 5

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Department Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
5 MAINTENANCE OF PERSONNEL	$	$	$	$	$	$		
6 LAUNDRY AND LINEN								
Laundry Direct Cost Per 100 lbs.								
Laundry lbs. Per Manhour								
Laundry lbs. Per Patient Day								
Laundry and Linen D. C. Per Bed (note 1)								
7 TOTAL NURSING SERVICE								
OB Manhours Per Bed Per Day (note 3)								
Med. Surg. Manhours Per Bed Per Day (note 3)								
All other Manhours Per Bed Per Day (note 3)								
TOTAL Nursing Manhours Per Bed Per Day (note 3)								
8 CENTRAL STERILE SUPPLY								
Direct Cost Per Bed (note 1)								
9 DELIVERY ROOM & POST PARTUM RECOVERY								
Number of Deliveries								
Direct Cost Per Delivery								
Manhours Per Delivery								
10 OPERATING ROOM & CYSTOSCOPY								
Number of Operations								
Direct Cost Per Operation								
Manhours Per Operation								

Exhibit B

Exhibit C

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OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 3 of 5

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Department Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
11 RECOVERY ROOM	$	$	$	$	$	$		
12 LABORATORY								
13 BLOOD BANK								
14 X-RAY DEPT. INCLUDING X-RAY THERAPY, AND ISOTOPE THERAPY								
Manhours per procedure								
Direct cost per procedure								
15 PHARMACY								
16 MEDICAL RECORDS AND LIBRARY								
Direct cost per bed (note 1)								
Manhours per bed (note 2)								
17 ANESTHESIOLOGY								
18 INHALATION THERAPY								
19 EMERGENCY ROOM								
20 AMBULANCE SERVICE								
21 CLINICS								

Exhibit B

Exhibit C

95a

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
22. ALL OTHER PROFESSIONAL SERVICES	$	$	$	$	$	$		
Physical Therapy								
Social Service								
Home Health Care								
Day Nursery								
Electrocardiograph								
Electroencephalograph								
Medical Photography & Illustration								
Speech Therapy								
Occupational & Recreational Therapy								
Extended Care								
23. MEDICAL EDUCATION								
(should agree with Form K, line 13)								
24. PARA-MEDICAL EDUCATION								
School of Nursing (R.N.)								
Other Education								
Direct Cost Per Bed (note 1)								
25. RESEARCH EXPENSES								
26. NON-REIMBURSABLE FUNCTIONS								

Exhibit B

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Exhibit C

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OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
27. NON-DEPARTMENTAL EXPENSES	$	$	$	$	$	$		
Payroll Taxes								
Fire, Liability, Malpractice & Other Insurance								
Group Life								
Hospitalization								
Major Medical								
Workmens Compensation								
Unemployment Insurance								
Tuition Refund								
Pension Costs								
Taxes Other than Payroll								
Other								
Interest—Capital Debt								
Interest—Working Capital Debt								
Depreciation and Leases								
28. TOTAL (should agree with amounts reported on Forms E, F, & G)								

Exhibit C

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Note 1—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total budgeted costs.

Note 2—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total paid hours.

Note 3—This is a daily statistic and is calculated by multiplying the total number of regularly maintained beds by 365 days and dividing the result into the total paid hours.

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Exhibit B

NOTE: Refer AHA Uniform Definitions (1963) for explanation of statistical terms.

OPERATING BUDGET
Statistics

FORM D
Page 1 of 3

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	Number of Beds Regularly Maintained	Total Patient Admissions	Total Patient Days	Average Length Of Stay	Percent Occupancy
Actual _____					
Major Services:					
Medical–Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Projected ____ ____ Months Actual ____ Months Estimated					
Major Services:					
Medical–Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Budget _____					
Major Services:					
Medical–Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					

Exhibit D

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OPERATING BUDGET
Statistics

FORM D
Page 2 of 3

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Service	Total	Inpatients	%	Outpatients	%
Laboratory Operations					
Clinical Lab Test:					
Actual _____					
Projected _____					
Budget _____					
Pathological Exams:					
Actual _____					
Projected _____					
Budget _____					

Radiological Operations					
Diagnostic X-Ray Procedures					
Actual _____					
Projected _____					
Budget _____					
Therapeutic X-Ray Procedures					
Actual _____					
Projected _____					
Budget _____					
Radio-Isotope Procedures					
Actual _____					
Projected _____					
Budget _____					

Exhibit B

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Exhibit C

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OPERATING BUDGET
Statistics

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Clinic Stastistics	Number of Clinics Operated	Total Clinic Hours Scheduled Weekly	Number of Visits Annually	No. of Patients Treated Annually
Actual ____				
Projected ____				
Budget ____				

Private Ambulatory Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Emergency Room Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Number of Operations	Total Number
Actual ____	
Projected ____	
Budget ____	

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
1. A. SERVICE DEPARTMENTS									
2. Administrative & General:									
3. Executive Offices									
4. Accounting and Fiscal Services									
5. All Other Administrative									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13. TOTAL Administrative & General									
14.									
15. Dietary (including Cafeteria)									
16.									

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
17.	PLANT:									
18.	Maintenance									
19.	Operation of Plant									
20.	Motor Service									
21.	Security									
22.	TOTAL Plant									
23.										
24.	Housekeeping									
25.	Maintenance of Personnel (Personnel Quarters)									
26.										
27.	Laundry									
28.	Linen, Bedding & Sewing Room									
29.	TOTAL Service Departments									

Exhibit B

Exhibit C

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OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
30.	B. PROFESSIONAL CARE OF PATIENTS									
31.	Nursing Service:									
32.	Nursing Service Administration									
33.	Obstetrics									
34.	Medical and Surgical									
35.	Intensive Care & Coronary Care Units									
36.	Pediatrics									
37.	Nursery									
38.	Psychiatric									
39.	Extended Care									
40.										
41.										
42.	TOTAL Nursing Service									
43.										
44.	Central Sterile Supply									

Exhibit B

Exhibit C

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OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
45	Delivery Room & Post Partum Recovery									
46	Operating Room & Cystoscopy									
47	Recovery Room									
48										
49	Laboratories									
50	Blood Bank									
51	Medical Photography & Illustration									
52	Diagnostic X-Ray									
53	X-Ray Therapy									
54										
55	Radio—Isotopes									
56	Renal Dialysis									
57										
58	Pharmacy									
59	Medical Records									

Exhibit C

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Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
60.	Medical Library									
61.	Anesthesiology									
62.	Inhalation Therapy									
63.	Electroencephlagraph									
64.	Electrocardiograph									
65.										
66.	Physical Therapy									
67.	Speech Therapy									
68.	Occupational & Recreational Therapy									
69.	Home Health Care									
70.	Social Service									
71.	Emergency Room									
72.	Clinics									
73.	Ambulance Service									

Exhibit C

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Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ___ Months Actual ___ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
74										
75										
76										
77										
78										
79	TOTAL Professional Services									
80	Medical Education (should agree with Form K, line 13)									
81										
82	C. PARA-MEDICAL EDUCATION									
83	School of Nursing									
84	School of Practical Nursing									
85	In-Service Education									
86	School of Medical Technology									

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Exhibit B

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Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ___ Months Actual ___ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
87.	School of X-Ray Technology									
88.										
89.										
90.	TOTAL Para-Medical Education									
91.	Research									
92.	Non Reimbursable Functions									
93.	TOTAL Salary & Wages—Employees & Fees (To Form A, line 1)	$			$			$		

R-2(1)

Exhibit C

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Exhibit B

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 1 of 7

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
1 SERVICE DEPARTMENTS			
2 Executive			
3 Accounting & Fiscal			
4 All other Administrative			
5 TOTAL Administrative			
6 Dietary (including Cafeteria)			
7 Plant			
8 Housekeeping			
9 Maintenance of Personnel (Personnel Quarters)			
10 Laundry			
11 Linen, Bedding & Sewing Room			
12			
13			
14 TOTAL Service Departments			
15			

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Exhibit C

106a

Exhibit B

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 2 of 7

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
16. PROFESSIONAL CARE OF PATIENTS:			
17. Nursing Service			
18. Central Sterile Supply			
19. Delivery Room & Post Partum Recovery			
20. Operating Room & Cystoscopy			
21. Recovery Room			
22. Laboratories			
23. Blood Bank			
24. Medical Photography & Illustration			
25. Renal Dialysis			
26.			
27.			
28.			
29. Diagnostic X-Ray			
30. X-Ray Therapy			
31.			

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Exhibit C

109a

Exhibit B

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
32.	Radio—Isotopes			
33.				
34.				
35.				
36.	Pharmacy			
37.				
38.	Medical Library			
39.	Medical Records			
40.				
41.				
42.	Anesthesiology			
43.	Inhalation Therapy			
44.	Electroencephalograph			
45.	Electrocardiograph			
46.				

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
47.	Physical Therapy			
48.	Speech Therapy			
49.	Social Service			
50.	Occupational and Recreational Therapy			
51.	Extended Care			
52.	Home Health Care			
53.	Emergency Room			
54.	Ambulance Service			
55.	Clinics			
56.				
57.				
58.				
59.				
60.				
61.				

Exhibit C
110a
Exhibit C
111a

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL	PROJECTED Months Actual Months Projected	BUDGET
62. Medical Education (should agree with Form K, line 13)			
63.			
64.			
65. TOTAL Professional Care of Patient Expenses			
66. PARA-MEDICAL EDUCATION:			
67. School of Nursing			
68. School of Practical Nursing			
69.			
70. In-Service Education			
71. School of Medical Technology			
72. School of X-Ray Technology			
73.			
74. TOTAL Para-Medical Education			
75. Research Expenses			

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL	PROJECTED Months Actual Months Projected	BUDGET
76. Non Reimbursable Functions			
TOTAL DEPARTMENTAL EXPENSES (Lines 1-76)			
NON-DEPARTMENTAL EXPENSES			
77. Payroll Taxes			
78. Fire, Liability, Malpractice & Other Insurance			
79. Group Life			
80. Hospitalization			
81. Major Medical			
82. Workmen's Compensation			
83. Unemployment Insurance			
84. Tuition Refund			
85. Pension Costs			
86. Taxes Other than Payroll			
87. Other			

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
88.			
89.			
90. TOTAL NON-DEPARTMENTAL EXPENSES			
91. TOTAL SUPPLIES & EXPENSES (To Form A, line 2)			
92. Interest Expense—Capital Indebtedness			
93. Interest Expense—Working Capital Indebtedness			
94. TOTAL INTEREST EXPENSE (To Form A, line 4)			

Note: Indicate Cost Center to which IV's are charged.

FORM G

OPERATING BUDGET
Depreciation Expense

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

	____ ACTUAL		____ PROJECTED		____ BUDGET	
	Method	Amount	Method	Amount	Method	Amount
1 Land Improvements		$		$		$
2 Buildings						
3 Fixed Equipment						
4 Automobiles and Trucks						
5 Major Movable Equipment						
6 Leasehold Improvements						
7 Minor Equipment						
8 Other						
9 TOTAL (To Form A, Line 3)		$		$		$

OPERATING BUDGET
Analysis of Recovery of Expense Items

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

ITEM	ACTUAL	PROJECTED	BUDGET
1 Telephone service (pay stations excluded)	$	$	$
2 Radio & television serv			
3 Laundry & Linen Serv			
4 Vending Machines Commission			
5 Employee and guest meals			
6 Sale of drugs to other than patients			
7 Sale of medical & surgical supplies to other than patients			
8 Sale of medical records and abstracts			
9 Sale of scrap, waste, etc			
10 Rental of quarters to employees and others			
11 Rental of hospital space			
12 Payments received from specialists			
13 Trade, quantity, time, and other discounts on purchases			

Exhibit B

OPERATING BUDGET
Analysis of Recovery of Expense Items

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

ITEM	ACTUAL	PROJECTED	BUDGET
14 Rebated and refunds of expenses	$	$	$
15 Gift, flower, and coffee shops			
16 Nursing School (tuition, fees, textbooks, uniforms, etc.)			
17 Grants, gifts, and income designated by the donor for specific expenses			
18 Recovery of insured loss			
19 Fund raising expenses			
20 Other (Specify)			
21 Other (Specify)			
22 Other (Specify)			
23 Other (Specify)			
24 Total (To Form A, line 6)	$	$	$

Exhibit B

OPERATING BUDGET
Personnel Policies

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

1. Indicate the current minimum hiring wage your institution is paying for unskilled labor.

RATE $ _____

2. Are there any plans to increase the above minimum wage during the budgeted period, please explain below.

_____

_____

_____

_____

3. Indicate the beginning rate on July 1 of budgeted year for the following personnel classifications.

Interns	$	Annually
Residents		Annually
Registered Nurses		Annually
Licensed Practical Nurses		Annually
Nursing Aides		Hourly
Orderlies		Hourly

4. Does the hospital provide any housing for employees? Indicate type of housing, number of units, any income, etc.

_____

_____

5. On what date do your employees receive their annual merit adjustments, i.e., employment anniversary, July 1, other ?

_____

6. Outline briefly union contracts in force. Include names of unions, number of employees in each bargaining unit and expiration date of contracts.

_____

_____

_____

_____

OPERATING BUDGET
Personnel Policies

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

7. Nursing Service Complement

	FTE.	Percent
RN's		
LPN's		
Aides		
All Other Nursing Personnel		
TOTAL—Per Form E, line 42		100%

8. How many hours constitute the regular work week? _____

Briefly explain the following policies of your hospital; or submit a copy of your personnel policies.

9. Premium Pay — Overtime _____
— On call pay _____
— Shift differential _____
— Call back Allowance _____

10. Number of holidays granted each year _____

11. Briefly explain vacation policy. _____

_____

_____

12. Employee benefits (indicate whether contributory or non-contributory) _____

_____

13. Sick leave benefits _____

_____

OPERATING BUDGET
Supplemental Questionnaire

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

1. Indicate by check those services or programs in which you participate

	YES	NO
H.A.S. (Hospital Administrative Services)		
P.A.S. (Professional Activity Study)		
M.A.P. (Medical Audit Program)		
P.A.T. (Pre-Admission Testing)		
OB/GYN mixing		
H.U.P. (Hospital Utilization Program)		
S.P.U. (Short Procedure Unit)		
M.C.U. (Minimal Care Unit)		

2. Indicate status of prior years cost filings with third parties (not amounts due) where final settlement has not been completed

Year	Blue Cross	Medicare	Medicaid

3. Indicate any service contracts which the hospital has for the performance of Patient Care Services, Data Processing, Dietary, Housekeeping, Laundry, etc.

_____

_____

_____

_____

Exhibit B

Exhibit C

120a

OPERATING BUDGET
Supplemental Questionnaire

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

4. Indicate any rentals and leases in excess of $5,000 per annum

_____

_____

_____

_____

_____

5. List new facilities, leases, programs or services, since July 1, 1975. Indicate the approximate annual direct costs and whether approval of an appropriate Planning Agency, if necessary was obtained

_____

_____

_____

_____

_____

6. Do you have approved intern and residency programs? ☐ yes ☐ no If yes, please list below

_____

_____

_____

_____

_____

7. Please attach a copy of most recent audited Financial Statement

8. List hospital based ancillary services which bill separately from hospital billing

_____

_____

9. Indicate name of public accounting firm employed by hospital for the budget year

_____

_____

Exhibit B

Exhibit C

121a

Exhibit C

FORM E

OPERATING BUDGET
Comparative Report Educational Expenses

Date Submitted: _____
B. C. Code No. _____

(HOSPITAL)

Fiscal Year: _____

PERSONNEL: Number F.T./P.T.	ACTUAL				PROJECTED				BUDGET				Percentage Variance Budget vs.	
	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Actual	Proj.
1 Interns	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
2 Residents	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
3 Director Med. Ed.	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
4 Secy. & Clerks	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
5 Teaching M.D.'s	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
6 Others	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
7 Total Expenses	$													
number F.T. P.T.	F.T. P.T.								F.T. P.T.					
EXPENSE OFFSETS														
8 Grants	$													
9 Fellowships	$													
10 Income-Affiliates	$													
11 Others	$													
12 Total Offsets	$													
13 Total Net Expenses	$													

Exhibit C

Exhibit C

EXHIBIT C

HOSPITAL SAFETY PROGRAM

In accordance with Section 16 of this Agreement, the Provider agrees to establish a safety program incorporating, as practicable and appropriate, the following principles:

1. Management Involvement.

(a) The basic program shall incorporate procedures designed to foster loss control and malpractice prevention, and shall be communicated in written form to key hospital personnel.

(b) Plans to implement the program and periodic progress reports shall be included on the agenda of top level management meetings.

(c) A Safety Committee shall be formed to include at least one trustee, administrative personnel, at least one physician, and other appropriate persons.

2. Education.

(a) The Safety Committee shall review incidents threatening the safety of patients.

(b) The Provider shall instruct medical personnel as regards the nature and legal implications of malpractice.

3. Policies and Standards for Reporting Incidents.

All incidents or unusual occurrences threatening the safety of patients shall be reported in writing to the chief administrative officer, or his designee, and the Safety Committee.

4. Accident Investigation.

The chief administrative officer, or his designee, shall make prompt investigation of all non-medical incidents and the chief medical officer, or his designee, shall inves-

tigate all medical incidents. The Safety Committee shall take appropriate steps to prevent assertions of malpractice and develop appropriate policies to implement such practice.

5. **Facility Inspections.**

The chief administrative officer, or his designee, shall inspect Provider's facilities regularly giving particular attention to equipment involved in critical patient care. All deficiencies or malfunctions shall be reported along with the corrective action taken. Medical personnel shall be designated to periodically inspect equipment involved in critical patient care.

6. **Supervisory Training.**

Procedures shall be established for the training of not only supervisory personnel, but all employees shall be included in the safety program.

7. **Group Meetings.**

Safety meetings shall be held periodically by each department of the Provider.

8. **Personnel Protection.**

The Provider shall provide protective equipment to appropriate personnel and ensure that such is periodically inspected.

9. **Contract Review.**

Purchasing arrangements, including arrangements for the purchase of drugs being used for experimental purposes, shall be carefully reviewed to ensure that suppliers have assumed responsibility for inherent defects in their products.

10. **Other Loss Control Programs.**

Programs shall be established to control and eliminate fire hazards, workmen's compensation losses, liability losses and other types of avoidable expenses.

Supreme Court, U. S.
FILED
FEB 2 1977
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

October Term, 1976.

No. 75-1691

PAUL I. GUEST, et al., Appellants

v.

F. EMMETT FITZPATRICK, et al.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, et al., Appellants

v.

F. EMMETT FITZPATRICK, et al.

On Appeal From the United States District Court for the Eastern District of Pennsylvania

ANSWER TO MOTIONS TO DISMISS No. 75-1691 BASED UPON MOOTNESS AND TO AFFIRM No. 75-1698 BASED UPON INTERVENING CIRCUMSTANCES

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ANSWER TO MOTIONS TO DISMISS No. 75-1691 BASED UPON MOOTNESS AND TO AFFIRM No. 75-1698 BASED UPON INTERVENING CIRCUMSTANCES.

1. Appellants do not oppose appellees' motion to dismiss No. 75-1691 since they are in agreement that the effect of the 1976 Hospital Agreement between appellants in No. 75-1691 ("DVHC hospitals") and appellee Blue Cross of Greater Philadelphia ("Blue Cross") is substantially to moot the issues presented by that appeal. Moreover, they agree that, in accordance with established procedure as specified in **United States v. Munsingwear, Inc.,** 340 U. S. 36, 39 (1950), it would be appropriate for this Court to dismiss the appeal in No. 75-1691 and to vacate the order below insofar as it is the subject of this appeal.

2. Appellants, however, oppose the motion to affirm No. 75-1698. They do so on the ground that No. 75-1698 is moot for precisely the same reasons as is No. 75-1691. The sole controversy presented by the appeal in No. 75-1698 was the impact of Pennsylvania Act No. 94 upon the pre-existing contract between Williamsport Hospital ("Williamsport") and the Hospital Service Association of Northeastern Pennsylvania ("Northeastern"), the relevant hospital plan corporation.[1] Although appellees were ap-

---

1. The appellants in No. 75-1698 are Williamsport, solely in its own behalf, and the Hospital Association of Pennsylvania ("HAP"), a professional organization in the nature of a trade association, which lacks legal authority to represent or bind its members before the Court. Both were plaintiffs-intervenors in the proceeding before the district court.

While the Amended Complaint at Civil Action No. 75-2306 below contains class action allegations (Appendix 32-33), no order certifying class status was ever entered and the opinion and order of the district court do not contain class findings as required by Rule 23(c)(3) of the Federal Rules of Civil Procedure. See Brief for Appellees at 15. Nor does the lower court's opinion and order

(footnote continued)

parently unaware of the fact when they filed their motion to affirm No. 75-1698, the parties to the affected contract have entered a new contract subsequent to the passage of Act 94, and, accordingly, that controversy is now moot upon the same reasoning advanced with respect to No. 75-1691.

It is undisputed that Williamsport has been operating since July 1, 1967 under a contract with Northeastern which is similar in pertinent respects to the "member" contracts between the DVHC hospitals and Blue Cross, but which is automatically renewable for successive one-year terms unless notice of termination is given ninety days before its July 1 anniversary date. (A copy of that contract, as amended by a Memorandum of Understanding, is attached hereto as Attachment A). The contract had been renewed on July 1, 1975. Thus, when Act No. 94 was passed on August 2, 1975, its effect was to lock Williamsport into a pre-existing contract for up to thirteen months beyond the agreed upon contract term. It was this requirement that it provide service under a retroactively extended contract which Williamsport challenged as unconstitutional. Under appellees' own reasoning, that challenge became moot when, on April 2, 1976, with full awareness of Act No. 94, Williamsport permitted the contract to go into another renewal term.

While Williamsport is still subject to the prospective hearing and negotiation provisions of Act No. 94 (as are the DVHC hospitals), the impact of the Act upon a contract entered into after its passage presents quite a different question from that which was originally raised by Williamsport in its Jurisdictional Statement and upon which this Court noted jurisdiction. Accordingly, there is

1. (Cont'd.)
reveal any intention to treat the matter as one involving or applicable to a class. *Cf.* **Richardson v. Ramirez,** 418 U. S. 24, 36-40 (1974).

no longer any case or controversy before the Court upon which to exercise its jurisdiction.[2]

3. Asssuming that both appeals are dismissed as moot, and the entire order below vacated, the continued harm to appellants in No. 75-1961 would not be so great as to justify opposing the Motion to Dismiss and asking the Court to exercise continuing jurisdiction. However, this is not to say that the DVHC hospitals and other members of the class they sought unsuccessfully to represent before the District Court would not be seriously prejudiced were any part of the opinion and order below to be permitted by this Court to remain in effect. *See, e.g.,* **Super Tire Engineering Co. v. McCorkle,** 416 U. S. 115 (1974); **Carroll v. President and Commissioners of Princess Anne,** 393 U. S. 175 (1968). Accordingly, if the Court declines to dismiss the appeal at No. 75-1698 upon grounds of mootness, it would be inappropriate for it to decide that case on the merits without also hearing argument in and deciding the companion appeal at No. 75-1691 out of which it originally arose.[3] There is no legal basis for treating the appeals differently, since whatever continued impact results from the effect of Act 94 upon future contract negotiations applies equally to the appellants in both appeals. Indeed,

2. At the time of the renewal, Williamsport did not consider the possible impact of that event upon the continuing viability of this appeal since, as will be discussed *infra* at paragraph 3, the order below is not without some continued impact. However, upon consideration of the arguments raised by appellees in their Motion to Dismiss No. 75-1691 and the relevant case law, all appellants now concur in the view that the disposition of the appeal at No. 75-1698 must follow that of the companion appeal.

3. Not only have Williamsport and HAP argued the appeal at No. 75-1698 as an aspect of and in the context of the appeal at No. 75-1691, but the entire record before the Court relates to the controversy in No. 75-1691 between the DVHC hospitals and Blue Cross.

to the degree that the appeals can be distinguished, the stronger argument against mootness exists in No. 75-1691 in that there remains a possible conflict between Act 94 and the 1976 Hospital Agreement as a result of which the Act may continue retroactively to deny certain DVHC hospitals rights which they had had before enactment of Act 94. Moreover, the DVHC hospitals had sought, if unsuccessfully, to represent the class of hospitals which includes many hospitals whose preexisting contracts were extended to their detriment by Act 94 and which could, had the class been certified, maintain this appeal.[4]

RELIEF REQUESTED.

For the reasons set forth in the above Answer to appellees' motions to dismiss No. 75-1691 and to affirm No. 75-1698 respectively, it is respectfully requested that appellees' Motion To Dismiss No. 75-1691 Based Upon Mootness be granted, that appellees' Motion To Affirm No. 75-1698 Based Upon Intervening Circumstances be denied, that the appeals in both cases be dismissed as moot, and that the order of the district court from which these consolidated appeals are taken be vacated and this cause remanded to the district court with a direction to dismiss. However, in the event that the Court should find it retains jurisdiction over any part of either appeal, it is respectfully

4. On the other hand, to the extent that the status of HAP or DVHC as appellants is relied upon for the proposition that they could maintain one or both of these appeals because there are hospitals represented by these organizations which still have contracts with hospital plan corporations entered prior to passage of Act 94, the Court should be aware of the serious question as to standing thereby presented. *See e.g.*, **Village of Arlington Heights v. Metropolitan Housing Development Corp.**, — U. S. — 45 U. S. L. W. 4073 (January 11, 1977).

submitted that it should deny both motions made by appellees and hear argument as originally scheduled upon both Nos. 75-1691 and 75-1698.

Respectfully submitted,

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17108
Of Counsel.

JAMES H. STEWART, JR.,

Attorneys for Appellants.

ATTACHMENT A

AGREEMENT
BETWEEN
HOSPITAL SERVICE ASSOCIATION OF
NORTHEASTERN PENNSYLVANIA, INC.
AND
THE WILLIAMSPORT HOSPITAL

THIS AGREEMENT made this 11th day of July, 1967, by and between the HOSPITAL SERVICE ASSOCIATION OF NORTHEASTERN PENNSYLVANIA, INC., a non-profit corporation hereinafter called "Blue Cross" and the WILLIAMSPORT HOSPITAL, hereinafter called "Member Hospital",

WITNESSETH: In consideration of the agreements hereinafter contained, the parties agree as follows:

I

THE MEMBER HOSPITAL AGREES:

A. To receive for Hospitalization, to the extent that accommodations are available, all Subscribers to Blue Cross who may apply for and be eligible without any charge to the subscriber for covered services specified in the member's Subscription Agreements issued, or to be issued, copies of which shall be furnished the Member Hospital.

B. To report to Blue Cross, upon admission of any Subscriber, notice of such admission on forms supplied by Blue Cross.

C. To furnish to Blue Cross, within 15 days of date of discharge and/or receipt of confirmation of benefits, statement of charges during hospital stay for services and credits extended to Sub-

scriber by Member Hospital on forms mutually agreed upon or furnished by Blue Cross.

D. To furnish copy of said statement to Subscribers of Blue Cross upon discharge or by mail to Subscriber's residence within 15 days after Blue Cross payment is received.

E. To extend Blue Cross benefits outlined in Subscription Agreements to any patient it may admit as an eligible Subscriber of an approved Blue Cross Plan.

F. To make available to Blue Cross all information and records, or copies of records, relating to care of Subscribers as are now normally furnished.

II

Blue Cross Agrees:

A. To reimburse the Member Hospital for patient services provided Subscribers, the lesser of 98% of patient charges, or a per diem rate based upon the cost of furnishing services to non-Medicare patients as hereinafter provided.

B. To furnish Member Hospitals with comparative statistical, financial, utilization, and other relevant data from time to time. Blue Cross further agrees that it will consult with and advise Member Hospitals on a continuing basis to assist them in cost reduction programs, in improving their capabilities, and in adapting various management techniques through its Cooperative Management Systems and Report Programs.

C. To present to the Hospital Advisory Committee any changes in membership Subscription Agreements prior to the adoption of said changes.

III

The Parties Hereto Agree That:

It is the intent of this Agreement that all necessary and proper net operating expenses incurred by a Member Hospital in providing patient care, including both direct and indirect costs, be recognized.

A. *Allowable Depreciation:*

1. An appropriate factor for depreciation on buildings and equipment is an allowable cost if the depreciation is:

   a. Identifiable and recorded on a hospital's accounting records.

   b. Based on the historical cost of the asset, or an appraisal of historical cost made by recognized appraisers, when records of purchased assets are not available, or at fair market value at time of donation, and

   c. Prorated over the estimated useful life of the asset using the straight-line method, or a mutually agreed upon percentage factor in lieu of straight-line depreciation, if the Member Hospital's records do not reflect the straight-line method.

2. The Chart of Accounts published by the American Hospital Association shall be used as the guide for determining the useful life of assets.

3. Gains and losses realized from the disposal of depreciable assets will be included in allowable costs. The extent to which gains and

losses are includable will be on a proration basis recognizing the amount of depreciation charged from the effective date of this Agreement to the total depreciation charged to the date of disposal.

4. Equipment items with a dollar value in excess of $100 and a life expectancy of over one year should be capitalized.

B. Items Not Includable as Operating Expense:

The Member Hospital shall not include as operating expense:

1. The expenses incurred by the Member Hospital in connection with any building program, including but not limited to, fund raising expenses, expenses of the hospital's public relations department, and, up to the time the building is completed, and in use, interest on construction loans.

2. Cost incurred for research and recognized educational activities, over and above usual patient care. Where research and recognized educational activities are conducted with and as part of patient care, the cost of usual patient care is allowable only to the extent that such costs are not met by funds provided for this purpose from other sources.

3. Expenses relating to the use and operation of vending machines and snack bars.

4. Expenses incurred in connection with investments and properties held for investment.

C. Deductible Items:

1. Revenues derived from areas or services not related to patient care, but including patient revenues for convenience items, will be deducted from related costs.

2. The cost of producing these revenues may be deducted in lieu of the revenue, provided the cost figures are acceptable to Blue Cross and the Member Hospital. Where there is no related cost, there will be no deduction.

   These income items include, but are not limited to:

   Abstract Fees, Telephone, Radio, Television, Sale of Drugs, Sale of Medical and Surgical Supplies, Photography, Identification Bands, Hospitality Shops, Employee Cafeteria Revenue, Vending Machines, Rental of Space, Sale of Scraps, Student Tuition, Rental of Quarters, Personal Laundry, Guest Trays, etc.

D. Computation of Reimbursable Costs:

1. The Member Hospital's operating expense calculated pursuant to the foregoing provisions shall constitute its net operating expense for patient care. From this amount shall be deducted the finally determined cost for Medicare patients exclusive of the Medicare allowance in lieu of specific recognition of other costs, and the remainder shall be accepted as a net operating expense for non-Medicare patients. The net operating expense for non-Medicare patients shall be divided into out-patient, nursery, and in-

patient care by accepted accounting practices.

2. The net operating expense for non-Medicare in-patients shall be divided by the number of non-Medicare days of care the hospital rendered to in-patients during the reporting period and the quotient shall be accepted as the Member Hospital's cost per non-Medicare in-patient day. In computing the number of days of hospital services furnished by the hospital to a Subscriber, the day of admission shall be counted, but not the day of discharge. If the patient fail to leave the hospital before the established discharge hour, he shall be responsible to the hospital for all charges incurred after that time.

3. For reimbursement of full benefit nursery cases, an average per diem rate based on the net allowable cost of care for the newborn and premature nursery (when such latter cost is included in this category) will be paid in addition to the cost of the mother's stay.

4. For out-patient cases, Blue Cross shall pay an average per patient rate based on the net allowable cost of care rendered in the out-patient department.

5. An allowance of 4% of the non-Medicare cost as determined above (with the exception of interest expense) shall be included as an allowance in lieu of specific recognition of other costs in providing and improving patient services providing that the Member Hospital will fund this specific allowance included in this Agreement.

6. In determining the reimbursement due the hospital, the charges payable by the Subscriber for patient care shall be credited to the Blue Cross obligation to the Member Hospital under this Agreement.

7. An allowance of 4% of essential charges not covered by the Subscriber's Agreement for the approved benefit period shall be included in the Member Hospital's reimbursement as a factor for bad debts.

8. The rate of reimbursement, as calculated above for the preceding 6 months, shall be used as the basis of determining the initial payment to be paid the Member Hospital during the next 6-months period. This initial rate of payment may be reviewed by the Member Hospital and Blue Cross prior to use, and modified to approximate the Member Hospital's anticipated costs. It shall also be subject to review and modification during the period at any time the hospital can justify an increase in its costs. Such initial payment shall be made on a weekly basis by Blue Cross.

9. In addition to the Initial payment, there shall be made, not less than semi-annually, an adjustment of payments on the basis described. At the end of each fiscal year, and after the Medicare costs for the entire year have been determined, the adjustments made semi-annually are subject to further review and adjustment.

10. Member Hospitals' report of statistics and costs shall be submitted to Blue Cross each six

months of the calendar year within 90 days after the end of the period. To assure uniformity in the determination of costs according to the reimbursement cost formula, such reports and Hospital books shall be subject to audit by Blue Cross.

11. In the event the reimbursable costs for any six-months reimbursement period are ascertained to be greater than the payments made for the period, Blue Cross will pay the amount due within 30 days of receipt of the cost report. Final settlement will be made upon completion of the audit.

12. In the event the reimbursable costs for any six-months reimbursement period are ascertained to have been less than the payments made for that period, the overpayment will be refunded by the Member Hospital within 30 days on a mutually agreed upon basis.

13. Payment for obstetrical cases or conditions relating to pregnancy under the Regular Semi-Private Agreement shall continue to be paid on the basis of the allowable indemnity.

14. Cases which involve Medicare patients holding Complementary Coverage shall continue to be paid on an indemnity basis, except for those in-patient days in excess of 90 days, which shall be reimbursed on the basis of the per diem cost determined herein.

15. The value of voluntary services provided by Sisters or other members of religious orders is allowable as an operating expense in an amount not to exceed those paid others for

similar work. Such amounts must be identifiable and recorded in the records of the Member Hospital.

E. Hospital Advisory Committee:

There shall be a Hospital Advisory Committee to Blue Cross of Northeastern Pennsylvania, which shall function in an advisory capacity to Member Hospitals and Blue Cross. The Committee shall be broadly representative of all Member Hospitals. The Committee shall meet quarterly, or more often if needed, and shall review with Blue Cross the implementation of, and any suggested changes in this Agreement.

This Agreement shall be for a period of one year from the effective date hereof, and shall be automatically renewed from year to year thereafter, except that after the initial term either party hereto may terminate this Agreement by giving to the other not less than ninety (90) days written notice; provided, however, the obligation of the Member Hospital to render hospital care under the terms of this Agreement shall not cease to all Subscribers of Blue Cross who were members prior to such termination until the end of their subscription year. And provided, further, that Blue Cross shall honor such subscribers of record by paying Member Hospitals at a rate calculated under the terms of this Agreement in effect at the time of termination any amount due under terms of Membership.

This Agreement supercedes and takes the place of all contracts between the parties hereto in existence prior to the execution hereof concerning the subject matter herein involved.

The effective date of this Agreement is July 1, 1967.

IN WITNESS WHEREOF the parties hereto have caused this Agreement to be executed by their authorized officers and their Corporate Seals to be hereunto affixed, the day and year first above written.

HOSPITAL SERVICE ASSOCIATION OF
NORTHEASTERN PENNSYLVANIA, INC.

Attest:

R. W. HARRIS
Assistant Secretary

By: RALPH S. SMITH
President

THE WILLIAMSPORT HOSPITAL

Attest:

C. R. WAXMAN, JR.
Secretary

By: HARRY R. GIBSON
President

MEMORANDUM OF UNDERSTANDING
BETWEEN
BLUE CROSS OF NORTHEASTERN PENNSYLVANIA
AND
THE WILLIAMSPORT HOSPITAL
(HOSPITAL)

MADE THIS 28TH DAY OF JUNE, 1972

IT IS AGREED THAT:

A. Member Hospitals will obtain the approval of planning agencies serving their area for any capital expenditure when the additional cost of such capital expenditure exceeds $100,000. If the project is not approved by the planning agency, Blue Cross reserves the right to refuse payment for this project. Member Hospitals agree to continue and expand efforts toward the combining of facilities and services in order to avoid costly duplication resulting in needless expense to the communities they serve.

B. Member Hospitals agree to provide all patients accommodations which are in substantial compliance with the standards of safety and quality of the Joint Commission on Accreditation of Hospitals and/or the American Osteopathic Association. Hospitals not now having properly constituted and operating Safety Committees agree to the prompt formation of such committees. Where existent, hospitals should evaluate all facets for current safety committee operation to assure appropriate representation, effective written policies and procedures, regular meetings and effective evaluation of performance.

C. Effective management and more meaningful control of costs is heavily dependent upon the rigorous discipline of the preparation of the detailed budget. The preparation of the annual budget is the responsibility of the administration acting within policy established by the governing body. Such budget should be approved annually by the governing body of the hospital. A financial and statistical summary of budget data will be submitted to Blue Cross annually for the purpose of providing information for setting Subscriber rates.

D. Member Hospitals will conduct continuing educational programs. Such programs will involve governing boards, medical staff and administration and shall include such items as pre-admission testing, timely scheduling, admission and discharge procedures, and adopt them where appropriate.

E. Member Hospitals and Blue Cross each agree, because an informed public is essential, to regularly publish (at least annually) such statistical, financial and other appropriate operating data as will provide the publics they serve with a means of evaluating and accounting for their stewardship.

F. Consistent with fair and equitable standards of selection and appraisal as developed by Governing Bodies, Administration and Medical Staffs, Hospitals agree to follow policies which will not deny to qualified physicians, who agree to meet the rules and regulations of the hospital, staff privileges.

G. Member Hospitals will avail themselves of the assistance provided for in the now-existing contract; wherein Blue Cross offers, "To furnish Member Hospitals with comparative statistical, financial, utilization, employee-to-patient ratio, and other relevant data from time to time. Blue Cross further agrees that it will consult with and advise Member Hospitals on a continuing basis to assist them in cost reduction programs, in improving their capabilities, and adapting various management techniques through its Cooperative Management Systems and Report Programs." Member Hospitals will act upon any reasonable recommendations.

H. An essential committee function of the medical staff is Utilization Review. Its goal is, through continuing educational effort, to assure the provision of the highest possible quality of care in the most effective and efficient manner. To achieve optimum performance, such committees must have available comprehensive data on individual hospital performance and comparative data from others. Hospitals agree that where such data is not now available to them, such data shall be obtained and used. Cost of such services are reimbursable by Blue Cross.

I. Depreciation based on "straight-line" historical costs will be allowed only if such allowance is (a) fully funded, or (b) used to pay principal of capital debt.

J. Contracts with and remuneration of hospital-based physicians or group practices must be reviewed and approved by Hospital governing bodies.

K. Economies can be achieved through appropriate purchasing policies for hospital supplies and equipment. Hospitals agree that, in purchasing, all reasonable steps will be taken to effect economies through affiliation with Group Purchasing organizations or other equally effective means.

L. Consistent with ethical standards of quality and suitability, hospitals agree to take prompt steps to implement or further their current practice of obtaining pharmaceuticals under a hospital and medical staff-approved generic drug ordering and prescribing system. Such systems and methodology as are used (or may be adopted) must not abridge the right of the attending physicians to order a drug of their choice, but they should clearly specify the right of the hospital to purchase and fill prescriptions generically in the absence of specific instructions to the contrary from the physician.

M. Member Hospitals, in order that, as much as possible, costly duplication be avoided, agree to accept test results and examinations performed outside the hospital when, as stated in the standards of the Joint Commission on Accreditation of Hospitals, such laboratories "have been given prior approval by the pathologist and medical staff" and when such tests are done "within a time reasonably proximate to the hospital admission to be acceptable."

N. The terms of this Memorandum of Understanding shall be coextensive with the now existing contract between the parties hereto, dated the 11th day of July, 1967 and any extensions thereof.

IN WITNESS WHEREOF, the parties hereto have caused this Memorandum of Understanding to be executed the month, day and year first above written.

BLUE CROSS OF NORTHEASTERN PENNSYLVANIA

By: RALPH S. SMITH

Title: *President*

THE WILLIAMSPORT HOSPITAL (Hospital)

By: C. R. WAXMAN, JR.

Title: *President*

Final Revision—per Member Hospital Administrators' Meeting of Friday, August 27, 1971.

Supreme Court, U. S.
FILED
FEB 4 1977
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

ANSWER OF APPELLEES TO SUGGESTION OF MOOTNESS IN No. 75-1698

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February 4, 1977

Answer of Appellees to Suggestion of Mootness in No. 75-1698

1. Appellees oppose Appellants' Suggestion of Mootness[1] in No. 75-1698, which (although the point is nowhere discussed in appellants' filing) would unjustifiably strip the Commonwealth of Pennsylvania and other appellees of an extremely important public benefit which they have derived from the judgment of the District Court.[2]

2. The District Court by a divided vote (J.S. in No. 75-1691 at A-16, A21-23, A26-27) upheld the validity of Act No. 94 insofar as it applied to the preexisting contract between The Williamsport Hospital ("Williamsport") and Hospital Services Association of Northeastern Pennsylvania, Inc. ("Northeastern Blue Cross"), a

[1] Appellants filing is styled "Answer to Motions To Dismiss No. 75-1691 Based Upon Mootness And To Affirm No. 75-1698 Based Upon Intervening Circumstances." Since it raises for the first time in this Court an issue as to the alleged mootness of No. 75-1698, the filing will be referred to herein as "Appellants' Suggestion of Mootness" or "Appellants' S.M.".

[2] Appellees are frankly mystified as to the substantive ground for the related suggestion that appellants in No. 75-1691 be admitted to argue in No. 75-1698. Although Appellants' Suggestion of Mootness (¶3 at 4) vaguely refers to "a possible conflict between Act 94 and the 1976 Hospital Agreement as a result of which the Act may continue retroactively to deny certain DVHC hospitals rights which they had had before the enactment of Act 94", appellants are not able to point to even *one* specific example of such a problem, and appellees, after months of negotiations over just such questions culminating in the 1976 Hospital Agreement, are similarly unaware of any issue arising during the retroactive period overlooked by the comprehensive settlement which is now memorialized by the 1976 Hospital Agreement (discussed in the Motions of appelles referred to in note 1, *supra*). Indeed, appellants' unqualified concession (Appellants' Suggestion of Mootness ¶1) that No. 75-1691 is moot necessarily confirms this fact. Since appellants in No. 75-1691 have already filed their briefs in this Court, appellants' suggestion on this score reduces to a request that the usual rule against oral argument by *amicus* be waived as to them.

contract which was in existence on the August 2, 1975 effective date of Act No. 94. By reason of appellants' concession of mootness in No. 75-1691 (Appellants' S.M. ¶ 1), the most challenging issue in these cases (*i.e.*, the validity of the contract reinstatement approach taken by Act No. 94 as to the appellants in No. 75-1691) has now disappeared. In light of this development Williamsport appears to have lost confidence in the substantiality of its attack on the judgment of the District Court, and now seeks to evade the bar of that judgment by suggesting that the Williamsport-Northeastern Blue Cross contract (Attachment A to Appellants' S.M.) has been superseded by a new contract effective July 1, 1976, mooting Williamsport's challenge to the validity of Act No. 94 (Appellants' S.M. ¶ 2).[3]

[3] Williamsport's co-appellant, The Hospital Association of Pennsylvania ("HAP"), seeks to evade the bar of the judgment below by suggesting (Appellants' S.M. at 1 n.1, 4 n.4) that it is an appellant solely in its own behalf and not as a representative of its members (which members include hospitals contracting with appellee Blue Cross of Greater Philadelphia and with Northeastern Blue Cross as well as hospitals contracting with other Blue Cross plans in the Commonwealth of Pennsylvania). HAP expressly brought this action on behalf of its members ("DVHC and HAP are organizations whose members are also members of the plaintiff hospital class within their respective geographic areas." Amended Complaint ¶ 1, Appendix at 27). In such circumstances, the association clearly has standing as the representative of its members. *Boston Stock Exchange* v. *State Tax Comm'n* CCH Supreme Court Bulletin at B 616 n.3 (January 12, 1977). Thus, even if this Court were to conclude that Williamsport's special circumstances mooted its individual claims, there clearly remains a "live controversy" as to the impact of Act No. 94 on existing and future contracts, and the failure to certify HAP as the representative of a class concerned with these issues will not moot the appeal in this Court. See *Craig* v. *Boren*, CCH Supreme Court Bulletin at B414-B415.

3. There are obvious problems with an assertion that the automatic operation of a renewal clause of a Blue Cross-hospital contract moots any Act No. 94 aggrievement which a hospital in Pennsylvania might have. For example, the principal effect of Act No. 94, if valid, would be to impair the previously unrestricted freedom of a hospital such as Williamsport to denounce the existing Williamsport-Northeastern Blue Cross arrangement at renewal time. Moreover, the alleged "new" contract was never approved by the Pennsylvania Insurance Department as required by 40 Pa.C.S. § 6124(a).

4. In any event, however, this Court need not pursue the foregoing inquiry, for in thus seeking to avoid the Scylla of one nonmoot issue (as to the effect of Act No. 94 on Blue Cross-hospital contracts existing on August 2, 1975), Williamsport has been swept into the Charybdis of a second and clearly nonmoot issue which it has most carefully presented and preserved. This second issue concerns the effect of Act No. 94 on *future* Blue Cross-hospital contracts (*i.e.*, contracts made after the August 2, 1975 enactment of the statute).

5. In Count II of the Amended Complaint in the District Court, Williamsport challenged the validity of Act No. 94 under the Equal Protection Clause insofar as the statute would apply to "future agreements" between, *inter alia*, Williamsport and North-

eastern Blue Cross (Appendix at 36-37 ¶¶ 21-26). The District Court reached the issue thus presented and, although divided on other aspects of the case, unanimously upheld the statute in its future aspects (J.S. in No. 75-1691 at A21-A23, A27). In this Court, Williamsport fully presented the issue in its Jurisdictional Statement (J.S. in No. 75-1698 at 18-19).

6. To be sure, Williamsport ultimately concluded that its attack on the prospective application of Act No. 94 was so patently frivilous that it could not responsibly be advanced in this Court, and with commendable candor abandoned the point ("Prospectively, the . . . statute is constitutional. . . ." Brief in No. 75-1698 at 14). Of course, the considerations typified by *United States* v. *Munsingwear, Inc.*, 340 U.S. 36, 39 (1950), are designed to protect an appellant who challenges a judgment below, but who finds his approach to review and hoped-for reversal in this Court frustrated by intervening events which undermine the constitutional basis of this Court's jurisdiction. In the instant action, on the other hand, this Court continues to be faced with a justiciable case or controversy between Williamsport and appellees as to the validity of Act No. 94 insofar as post-August 2, 1975 Blue Cross-hospital contracts are involved. Only Williamsport's perception of the substantiality of that question has changed during the course of this litigation.

7. Here, then, we discern the apparent motive for the extraordinary circumstance of an appellant, in a case where jurisdiction has been noted and the case fully briefed in this Court, pressing the issue of mootness. If Williamsport had perceived after judgment below that its challenge to the prospective application of Act No. 94 was insubstantial, it presumably would not have appealed, and the judgment would be *res adjudicata* as to it. Similarly, if Williamsport were now to dismiss unilaterally under Rule 60, the judgment below would be unaffected.[4] Only by persuading this Court to misapply *Munsingwear* can Williamsport (it having conceded in this Court that there is no merit to its attack on the judgment below) hope to escape the *res adjudicata* effect of the judgment of the District Court.

8. The danger to the public interest in the Commonwealth of Pennsylvania presented by Williamsport's facile maneuver is by no means fanciful. By Williamsport's own calculations, it is facing within a few weeks (*i.e.*, on April 2, 1977) another deadline for the annual renewal of its contract with Northeastern Blue Cross. If Williamsport succeeds in obtaining a gross misapplication of *Munsingwear* in this case, Williamsport will be free, should it so choose, to purport to denounce

[4] In view of the public nature of the question involved appellees have offered to waive all claim against appellants for costs here and below if the judgment of the District Court is permitted to stand in consequence of unilateral dismissal under Rule 60.

its existing contract with Northeastern Blue Cross and to begin a whole new round of litigation challenging the validity of Act No. 94 as to it. Nothing in the precedents of this Court, nor any concept of justice or sound judicial administration, requires that Williamsport, having brought its claim to the eve of oral argument in this Court, now be permitted to retire at its whim to relitigate the claim, in perhaps another forum,[5] on another day.

Respectfully submitted,

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[signatures continued on next page]

[5] While these cases arise from judgments of the United States District Court for the Eastern District of Pennsylvania, Williamsport's hospital facilities are located in the Middle District of Pennsylvania.

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IN THE

Supreme Court of the United States

October Term, 1975.

No. 75-1691.

PAUL I. GUEST, President of Methodist Hospital, CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of St. Joseph's Hospital, METHODIST HOSPITAL, and DELAWARE VALLEY HOSPITAL COUNCIL, on Behalf of Themselves and All Others Similarly Situated,

Appellants,

v.

F. EMMETT FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in Their Official Capacities, THE INSURANCE DEPARTMENT OF THE COMMONWEALTH OF PENNSYLVANIA, and BLUE CROSS OF GREATER PHILADELPHIA,

Appellees.

On Appeal From the United States District Court for the Eastern District of Pennsylvania.

BRIEF FOR APPELLANTS.

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IN THE

Supreme Court of the United States

—

OCTOBER TERM, 1975

—

No. 75-1691

—

PAUL I. GUEST, et al.,

Appellants,

v.

F. EMMETT FITZPATRICK, JR., et al.,

Appellees.

—

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA.

—

BRIEF FOR APPELLANTS.

—

OPINION BELOW.

The majority and dissenting opinions of the United States District Court for the Eastern District of Pennsylvania are reported at 409 F. Supp. 818. Copies of the opinions are appended to the Jurisdictional Statement at J. S. App. A5-A23 and J. S. App. A26-A32.[1]

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1. References to "J. S. App. A—" are to pages of the Appendices to the Jurisdictional Statement. References to "A. —" are to pages of the printed Appendix.

JURISDICTION.

The decision and final order of the three-judge court were entered on March 2, 1976 (J. S. App. A24-A25) and notice of this appeal was filed in the United States District Court for the Eastern District of Pennsylvania on March 22, 1976 (J. S. App. A34). Probable jurisdiction was noted on October 4, 1976.

The jurisdiction of this Court is invoked under 28 U. S. C. § 1253, this appeal having been taken from an order denying, after notice and hearing, a permanent injunction in a civil action required by Act of Congress (28 U. S. C. § 2281) to be heard and determined by a district court of three judges.

CONSTITUTIONAL PROVISIONS AND STATUTE INVOLVED.

The Contract Clause of the Constitution of the United States, Article 1, Section 10, provides:

> "No State shall . . . pass any . . . Law impairing the Obligation of Contracts . . . ."

The Due Process Clause of the Constitution of the United States, Amendment 14, Section 1, provides:

> ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law . . . ."

The Statute Involved, Act 94 of the 1975 Session of the Pennsylvania Legislature (Act of August 2, 1975, P. L. 293, amending Section 6124 of Title 40 of the Pennsylvania Consolidated Statutes), is reproduced in the Addendum to this Brief.

QUESTIONS PRESENTED.

1. Do not the Due Process and Contract Clauses prohibit retroactive state legislation which effects a substantial impairment of vested contract rights and a taking of property without just compensation, even though the state purports to have so legislated in accordance with its view of the public welfare?

2. Assuming *arguendo* that legislation which, on its face, reinstates and extends private contracts may be treated as the legal equivalent of rate regulation, does not the Constitution protect private, non-profit hospitals from being compelled to render service at rates which do not permit them to recover their full historic costs of doing business?

3. Absent any state hearing procedure through which the hospitals could protest their being obliged to provide service at non-compensatory rates, was not the district court at least obliged to grant the hospitals a hearing on their allegation that the rates under which Act 94 compels them to provide service are confiscatory?

STATEMENT OF THE CASE.

This class action was brought by 37 hospitals in the Philadelphia area (the "Delaware Valley Hospitals") and certain of their executive officers, administrators and employees on behalf of themselves and all others similarly situated. Seeking declaratory and injunctive relief, plaintiffs challenged the constitutionality of an act of the Pennsylvania legislature ("Act 94") which reinstated a terminated contract between the Delaware Valley Hospitals and Blue Cross of Greater Philadelphia ("Blue Cross") and imposed statutory restraints on the rights of hospitals to terminate contracts with hospital plan corporations like Blue Cross.[2] The case was heard by a three-judge court, as required by 28 U. S. C. § 2284, upon cross motions for summary judgment. This appeal is taken from the order of that court, with one judge dissenting, upholding the constitutionality of Act 94, denying the requested injunction, and granting summary judgment to the defendants.

Act 94 (approved August 2, 1975 and effective immediately upon approval) amended Chapter 61 of Title 40 of the Pennsylvania Consolidated Statutes. Chapter 61 provides for the certification and regulation by the Pennsylvania Insurance Department of hospital plan corporations authorized to establish, maintain and operate plans whereby subscribers to the plans will be provided prepaid hospitalization or related health benefits.

Blue Cross is a hospital plan corporation certified under Chapter 61. Under its contracts with subscribers ("subscriber contracts"), Blue Cross agrees to provide one of two different kinds of benefits depending upon whether the hospital from which the subscriber receives services

2. Named as defendants were Blue Cross, F. Emmett Fitzpatrick, Jr. (District Attorney of Philadelphia), Robert P. Kane (Attorney General of the Commonwealth of Pennsylvania) and the Insurance Department of the Commonwealth of Pennsylvania, each of whom has responsibility for the enforcement of Act 94.

has become a "member hospital," that is to say a hospital which has entered into a second kind of contract (a "membership contract") with Blue Cross. In cases where the subscriber obtains services from a "member hospital" Blue Cross will pay the hospital directly for the services furnished the subscriber in accordance with the payment formula contained in the membership contract between the hospital and Blue Cross. A member hospital agrees to accept payment under the terms of its membership contract with Blue Cross and gives up the right to obtain payment from its Blue Cross subscriber-patients except to the extent that individual subscriber contracts may require the subscriber to pay a small portion of the hospital bill as "co-payment" (Affidavit of Bruce Taylor, President of Blue Cross, ¶¶ 7, 10; A. 79, 80-1).

Alternatively, where a subscriber is admitted to a hospital which is not a member hospital, *i.e.*, a hospital which does not have a currently effective contract with Blue Cross, the subscriber-patient remains liable to the hospital for the normal charges of his or her hospitalization and treatment and is entitled to receive from Blue Cross only what is called an "indemnity benefit." Typically, the Blue Cross indemnity payment will be much less than the amount of payment called for under the usual membership contract, and accordingly less than full hospital charges (Affidavit of Bruce Taylor, ¶ 20; A. 83-4).

Act 94 was enacted as a legislative response to a particular factual situation involving the membership contract between Blue Cross and the Delaware Valley Hospitals (the "Delaware Valley Agreement").

Contractual Background.

On July 1, 1971, the Delaware Valley Hospitals acting through a common bargaining agent, the Delaware

Valley Hospital Council ("DVHC"), negotiated a two year membership contract with Blue Cross (Exhibit 17; A. 147a-262a), which provided for payment according to what Blue Cross denominates as a "reasonable cost reimbursement" formula. Under this formula, the Delaware Valley Hospitals were reimbursed the specifically identified costs of services rendered individual Blue Cross subscribers, but were not reimbursed for any part of certain other traditionally accepted costs of operating a hospital. These are costs which are not identified to particular paying patients, but costs which must be recovered nonetheless from total patient revenues if non-profit hospitals such as appellants are to maintain a balanced operating budget (Affidavit of Edward J. Armstrong, ¶ 4; A. 71-2, and Supplemental Affidavit of Joseph A. Williamson, ¶ 17; A. 117-18).

Foremost among the costs incurred by the hospitals but not recognized by the Blue Cross "reasonable cost reimbursement" formula are costs associated with unreimbursed patient care. This includes the cost of providing care to indigents and the cost of services provided non-indigents for which the hospitals are unable to collect charges. A substantial portion of the latter expense stems from bad debts of patients who enter the hospitals as Blue Cross subscribers and then exhaust coverage before they are discharged (Supplemental Affidavit of Joseph A. Williamson, ¶¶ 3, 4; A. 112-13). In accordance with sound fiscal policy, these costs are normally allocated and billed by the hospitals on a pro rata basis to all private paying patients (Affidavit of Edward J. Armstrong, ¶ 3; A. 71).

In order to make up for the losses produced by the exclusion of these expenses from the "reasonable costs" recognized by the Blue Cross payment formula, the prior membership contract between Blue Cross and DVHC, dated July 1, 1967, had included what was called a "plus factor"—an additional unrestricted grant by Blue Cross to

the hospitals over and above cost reimbursement (Supplemental Affidavit of Paul I. Guest, ¶ 4; A. 103-05). However, the 1971 contract contained no "plus factor" and, indeed, no mechanism to permit the hospitals to recoup losses represented by the difference between the amount of charges allocable to Blue Cross subscriber-patients and the amount of reimbursement actually paid by Blue Cross. This problem was further exacerbated by the fact that the 1971 contract (Section 18.4.1) contained a ceiling limitation on Blue Cross payments in terms of a stated percentage of the prior year's costs (A. 171a).

Appellants are non-profit hospitals which have no profit margin within which to absorb the costs of "discounted" payments from Blue Cross (Affidavit of Edward J. Armstrong, ¶¶ 4, 9; A. 71-2, 73). Thus, the amount of these Blue Cross underpayments necessarily resulted in net operating losses, whether they were recognized immediately or simply pushed forward to some future date by borrowing against reserves set up for replacement of fully depreciated facilities and equipment.[3] There was no Dela-

3. There are only a limited number of sources from which a non-profit hospital may recover the operating expenses which Blue Cross refuses to pay. Some part may be surcharged to those private patients who are self-insured or covered by commercial insurers. While in most cases it is not possible to impose the entire burden on this relatively small segment of the patient population, the need to reduce losses by surcharging private paying patients has resulted in situations in which, in extreme cases where private patients are relatively few in number, private insurers have paid full charges as much as 40% more than the amounts paid by Blue Cross for comparable services rendered its subscribers (Supplemental Affidavit of Joseph A. Williamson, ¶ 7; A. 114).

To the extent that the pool of private paying patients is too small to make up the total deficiencies in Blue Cross payments (and, as the burden of these deficiencies on the private paying patients becomes greater, more members of this group who are able to do so are under pressure to become Blue Cross subscribers, thus shrinking the size of the private patient pool and increasing accord-

ware Valley Hospital which did not suffer a loss under the 1971 Agreement. The amount of loss varied from a low of $50,000 per year in the case of Jeanes Hospital through $203,400 reported by Presbyterian-University of Pennsylvania Medical Center to more than $655,000 reported by Mercy Catholic Medical Center for fiscal year 1974 (Affidavit of Edward J. Armstrong, ¶ 10; A. 73; Supplemental Affidavit of Joseph A. Williamson, ¶ 6; A. 113-14).

Despite the Delaware Valley Hospitals' dissatisfaction with the reimbursement formula, the 1971 contract, which was terminable upon 90 days' notice and should have expired by its terms on July 1, 1972, was continued for an extended period of futile negotiations before it was finally permitted to terminate on March 31, 1974.

The Delaware Valley Agreement contained a ceiling limitation on Blue Cross payments for the first contract year only, providing further that unless new payment terms could be negotiated six months prior to the end of the first year, the contract would terminate as of July 1, 1972. However, although no new contract terms had been negotiated, when, on July 1, 1972, federal price controls

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3. (Cont'd.)

ingly the burden on each member), the hospitals must reduce their net operating loss from non-operating income sources. Thus, they use unrestricted endowment fund income where available and, in at least one case, endowment fund principal to the extent permitted by law (Supplement Affidavit of Joseph A. Williamson, ¶¶ 8 and 9; A. 115). The most common device, however, is for the hospitals to meet their current operating needs by utilizing that portion of Blue Cross payments which is supposed to be funded for a depreciation reserve. In some cases, it is necessary for a hospital to use up virtually all of its depreciation reserve to meet its daily operating needs. In this way, the hospital remains "solvent" by pushing forward its bottom line operating loss to some future time when it will be unable to replace fully depreciated facilities and equipment (Supplemental Affidavit of Joseph A. Williamson, ¶ 10; A. 115).

were in effect under the Economic Stabilization Act, the hospitals and Blue Cross agreed that the contract would continue and the hospitals would be reimbursed their allowable costs as approved by Blue Cross for the prior year plus only that increase permitted by the applicable federal control ceilings (Exhibit 18; 263a).

The parties still had not been able to reach agreement on a new contract when the agreement, as amended, terminated on July 1, 1973. They continued to negotiate, however, and in January 1974, agreed to a "Summary of Principles" retroactive to the July 1, 1973 termination date as the basis for an ongoing contractual relationship (Exhibit 20; A. 269a). The Summary of Principles basically continued in effect until March 31, 1974, with some minor modifications, the previous hospital agreement as modified by the 1972 amendment. Thus, through March 31, 1974, the Delaware Valley Hospitals continued to accept reimbursement from Blue Cross in accordance with the ceilings imposed by federal economic controls.

When the parties failed to reach agreement on a new contract by March 31, 1974, the agreement, as modified and extended by the Summary of Principles, terminated and a 90 day "continuation" period commenced. By agreement, this "continuation" period was extended for an additional 31 days until July 31, 1974 (Affidavit of Bruce Taylor, ¶ 35; A. 87). Finally, on August 1, 1974, the hospitals rejected Blue Cross' attempt to extend the agreement unilaterally to August 15, 1974.

As the court below found, "[i]t was the cost reimbursement formula that led to the breakdown of negotiations . . ." (409 F. Supp. at 820; J. S. App. A7). The Delaware Valley Hospitals believed that they could not continue to absorb the losses created by the exclusions from the Blue Cross "reasonable cost reimbursement" formula. Thus,

DVHC took the position throughout the negotiations that it must have a "plus factor" sufficient to cover the unrecognized costs properly allocable to charges for Blue Cross subscriber-patients (A. 319a). Ultimately, the Pennsylvania Insurance Department recommended the inclusion of a "plus factor" as a basis for negotiations between Blue Cross and DVHC (Supplemental Affidavit of Paul I. Guest, ¶¶ 2-5; A. 102-05). However, while negotiations proceeded for a time on the assumption that a "plus factor" would be included, Blue Cross ultimately persisted in its refusal to offer DVHC anything beyond the so-called "reasonable cost reimbursement" formula.[4]

The hospitals were not fully released from the limited cost reimbursement under the Delaware Valley Agreement when the contract terminated in March, 1974 and the continuation period expired in August, 1974. Rather, on August 15, 1974, a contractual twelve-month "run-out" period commenced.[5] This resulted from the fact that the Delaware Valley Agreement provided that, following its termination as a general contract, the agreement would continue in effect on an individual basis for the remainder of any individual subscriber contracts entered into during

4. Within a few days of the passage of Act 94, the DVHC negotiators and the attorney for Blue Cross, through the efforts and in the presence of Pennsylvania's Deputy Insurance Commissioner, reached complete agreement on a package settlement which was acceptable to the Insurance Department and to the negotiators. The proposed contract was accepted by the hospitals, but was rejected by the Blue Cross Board of Directors. This proposed contract included a plus factor of 4% per year for each of three years (Supplemental Affidavit of Paul I. Guest, ¶¶ 7-10; A. 105-07; Supplemental Affidavit of Joseph A. Williamson, ¶ 15; A. 117).

5. The August 15, 1974 date for commencement of the "run-out" period was arrived at as a result of a settlement in an independent action brought by the hospitals in April, 1974 to require elimination of the cost ceiling on Blue Cross payments during the "run-out" period (Exhibit 23; A. 286a-89a).

the pendency of the hospital contract.[6] No Blue Cross subscriber was deprived of any prepaid benefits, since the "run-out" provision obligated Blue Cross to pay, and the hospitals to accept, payment upon the terms of the expired contract for services rendered any subscriber during the yet unexpired term of his or her individual subscriber contract. It was only when an individual subscriber's contract expired upon reaching its anniversary date (subscriber contracts being for one year terms) that the subscriber became liable for the total allocated costs of hospital services received and Blue Cross became obligated under any subsequent renewal of the subscriber contract only to the extent of the "indemnity benefits" provided subscribers with respect to treatment received at "non-member" hospitals (Affidavit of Bruce Taylor, ¶ 37; A. 88).

The "run out" period would have ended on August 15, 1975. Thus, when Act 94 became effective on August 2, 1975, the hospitals were limited in their right to recover full patient charges from only the last few Blue Cross subscribers still subject to the "run out" provisions. All other Blue Cross subscriber-patients were obligated to

6. Section 27 of the Delaware Valley Hospital Agreement provided as follows (Exhibit 17; A. 182a-83a):

"Obligations after Termination

"In the event this Agreement terminates for any of the reasons set forth herein, the Provider [hospital], if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the time of their admission to the Provider, and (a) who were admitted to the Provider or treated as outpatients during the ninety day period following the date of such termination; or (b) who were inpatients on the date of such termination; or (c) who were admitted to the Provider during the unexpired portion of their agreement year current at the termination, i.e., the date 90 days after the delivery of notice of termination under subsection 26.1 or the similar date under other sections."

pay the full charges associated with their hospitalization and treatment. Blue Cross itself has pointed out that, from the perspective of the hospitals, this circumstance "did not make the negotiation of a new [limited cost reimbursement] contract desirable" (Affidavit of Bruce Taylor, President of Blue Cross, ¶ 39; A. 89).

Act 94.

It was at this point that the Pennsylvania legislature stepped in. On August 2, 1975, Act 94 was signed, effective immediately. The Act reinstated the terminated contract between the Delaware Valley Hospitals and Blue Cross retroactive to the time of its original termination sixteen months earlier (March 31, 1974), and extended its term for up to thirteen months from the time of notice of any subsequent attempt to terminate. The Act provided, meanwhile, than there would be no adjustment of the reimposed contract rates unless a new contract was negotiated. The legislature thus put pressure on the Delaware Valley Hospitals to accept an offer which they had refused through more than two years of negotiations.

By its terms, Act 94 provides that no contract between a hospital plan corporation and an eligible hospital may be terminated except upon 90 days' notice and subject to prior approval of the Pennsylvania Insurance Department (Section 1(c)(1)-(2)). When the hospital or hospitals involved have more than 5% of the beds in an area served by a hospital plan corporation, as do appellants here, the Insurance Department is required to hold public hearings and is authorized further to suspend termination of that contract for a period of up to ten additional months during which time the contract sought to be terminated is to continue in full force and effect while the Insurance Department holds hearings and may supervise contract negotiations (Section 1(c)(3)-(4)).

The key to the effectiveness of Act 94 is provided in Section 1(c)(5) which allows for adjustment of the imposed rates only if a new contract is successfully negotiated, i.e., "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties." **The Act makes no provision for any adjustment in payments made under the revived and extended contracts if a new agreement is not negotiated.***

While the Act is not limited on its face to the Delaware Valley Hospitals, the retrospective provisions make it clear that the Act was aimed at the Delaware Valley situation. Thus, it is explicitly provided at Section 2(2) that the Act shall apply retroactively to the termination of any covered contract "under which subscribers [of the Hospital Plan Corporation] received prepaid benefits on or after June 30, 1974 . . . [which] contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of the act."

Proceedings Below.

On September 12, 1975, appellants filed an Amended Complaint on behalf of a class comprised of all hospitals which were or are parties to contracts covered by Act 94 and all executive officers, administrators and employees of those hospitals who would be exposed to criminal prosecution under section 6105 of Title 40 for violations of the Act. Appellants sought to have Act 94 declared unconstitutional and its enforcement preliminarily and permanently enjoined (A. 26-35).[7] The case was assigned

* Wherever boldface is used in the brief the emphasis is ours.

7. The original Complaint (A. 4-19) was filed on August 11, 1975, but was amended in accordance with a subsequent stipulation of the parties (A. 23-5).

to a three-judge court in accordance with 28 U.S.C. §§ 2281 and 2284 (A. 68), and was heard on cross motions for summary judgment (A. 69-70; 76) and supporting affidavits (A. 71-5; 77-94).

On March 2, 1976, a final opinion and order of the three-judge court was entered by District Judge Charles R. Weiner, joined by Circuit Judge Francis L. Van Dusen, denying appellants' motion for summary judgment and granting appellees' motion for summary judgment upon appellants' request for permanent injunctive relief. District Judge Alfred L. Luongo, dissenting, would have held Act 94 unconstitutional in its "retrospective effect" or at the least would have required that there be a trial of the disputed issues of fact (409 F. Supp. at 828; J. S. App. A26).

Appellants filed notice of this appeal (J. S. App. A34) and a protective appeal to the United States Court of Appeals for the Third Circuit on March 22, 1976. A separate notice of appeal to this Court was filed March 24, 1976, by the Williamsport Hospital and the Hospital Association of Pennsylvania, plaintiffs-intervenors below. This Court noted probable jurisdiction on October 4, 1976, 45 U. S. L. W. 3248, and ordered the cases to be consolidated for argument.

SUMMARY OF ARGUMENT.

This case cannot be made to fit appellees' characterization of it as a dispute between the hospital and the patient with Blue Cross as intermediary between the two (Motion To Affirm at 2). It is better characterized as one involving an abusive exercise of the legislative process on behalf of one privileged segment of the patient class at the expense of other members of that class and at the risk of destroying the private non-profit hospital as a viable social institution.

The Delaware Valley hospitals are not commercial ventures, but non-profit institutions with an historic duty of community service. That portion of their charges which Blue Cross refuses to pay is not excess profits. Rather, it includes such necessary and traditional costs of running a hospital as that of providing care to indigent patients, as well as such generally accepted costs of doing business as that of writing off bad debts (including a substantial portion attributable to patients entering the hospital as Blue Cross subscribers and exhausting their coverage before their treatment is complete). Since appellant hospitals have no profit margin within which to absorb these costs and, unlike Blue Cross, cannot appeal to a regulatory body to bail them out of cash flow difficulties, it is a simple economic fact that, unless the hospitals are to be made financially dependent on dwindling sources of private philanthrophy, they must be able to recover from patient revenues what they expend in providing patient services.

It is in recognition of this economic fact of life that the Delaware Valley Hospitals maintained through two years of unsuccessful negotiation that they could not renew their membership contract under the terms of Blue Cross' limited "reasonable cost reimbursement" formula and, upon Blue Cross' refusal to augment its payments, that

they were forced to let the Delaware Valley Agreement terminate in March of 1974.

Thus, the hospitals did not hastily obtain or frivolously assert the right to full payment which was wiped out by the Pennsylvania legislature sixteen months later when, by legislative legerdemain, Pennsylvania suddenly breathed life into the terminated contract. As the majority below recognized, Act 94 not only put the Delaware Valley Hospitals back under the contract and extended it for up to thirteen additional months, it also required the hospitals to give back full charges already collected for services rendered Blue Cross subscriber-patients and to accept instead only limited cost reimbursement.

In this respect, the Act is patently unconstitutional. Insofar as it reaches back to deprive the Delaware Valley Hospitals of rights lawfully earned and executed before its passage, it effects an unconstitutional impairment of their contract rights and an unconstitutional deprivation of their property without due process of law.

In addition, the payment formula imposed by Act 94 is confiscatory on its face. There is neither explanation nor justification for the exclusion of costs which have long been recognized as legitimate costs of doing business and are among the traditional costs of running a hospital. Thus, even if Act 94 may be characterized as rate regulation insofar as it merely extends contracts which are or are deemed to be presently in force, it is nonetheless unconstitutional since it compels the hospitals to provide service under a "rate" formula which is non-compensatory. With respect to the Delaware Valley Hospitals the non-compensatory nature of the payment formula serves to make its fully retroactive application to patient services already rendered, billed and paid for even more outrageous.

Finally, assuming *arguendo* that the payment formula imposed by Act 94 is not confiscatory as a matter of law, appellees still were not entitled to summary judgment. Appellant hospitals are entitled to a judicial hearing at which they will have the opportunity to demonstrate as a matter of fact that the rate of payment imposed by Act 94 is confiscatory.

ARGUMENT.

I. THE DUE PROCESS AND CONTRACT CLAUSES BAR THE COMMONWEALTH OF PENNSYLVANIA FROM REVIVING A TERMINATED CONTRACT WHICH RESULTS IN THE SUBSTANTIAL IMPAIRMENT OF VESTED CONTRACT RIGHTS.

After termination of the Delaware Valley Agreement in March, 1974 and subsequent continuation periods, the hospitals had the absolute right on August 15, 1974 to contract with Blue Cross subscriber-patients, as they would with any other private paying patients, for the payment of full normal charges for services received. Such contracts were made and performed by the hospitals; Blue Cross subscriber-patients were billed for full charges; and in most cases, payment was made. This was until August 2, 1975, when the legislature decreed through Act 94 that the Delaware Valley Agreement was not terminated, thus, in effect, voiding all the direct contracts between the hospitals and subscriber-patients which had followed upon its supposed termination.

Moreover, the legislature declared that the Delaware Valley Agreement and all other membership contracts presently in force could only be terminated after three months' notice, after up to six months of public hearings, after up to three months of supervised negotiations and after still another month for no particular purpose whatever (Section 1(c)(2)-(4)). It is crucial that, while the Insurance Department is to supervise these proceedings and is authorized to approve any new contract negotiated, the Department has no authority to require the negotiation of a new contract upon terms which it finds to be reasonable. Thus, after thirteen months of proceedings, Blue Cross can still refuse to agree to a contract providing

for full payment and the hospitals would not be entitled to recoup any part of the losses inflicted upon them by Act 94.

Yet, in spite of these undeniable facts, the majority below found there had been no prohibited impairment of the hospitals' contract rights nor any unconstitutional deprivation of their property. The majority's reasoning was that "[t]he public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here" (409 F. Supp. at 824; J. S. App. A15).

This is a patently incorrect legal conclusion. This Court's decisions in the cases dealing with mortgage moratorium measures for the relief of debtors during the great Depression clearly support the conclusion of the dissenting judge in the court below who recognized that a state may not effect an impairment of private contract rights which is so substantial as to constitute a taking of property without just compensation "[n]o matter how great the public need" (409 F. Supp. at 829; J. S. App. A29).

In **Louisville Joint Stock Land Bank v. Radford,** 295 U. S. 555 (1935), this Court struck down the Frazier-Lemke Act, a federal law which permitted mortgagors to redeem property at its appraised value without reference to the actual debt outstanding. The Court held that the forced surrender of property so long as any part of the debt secured thereby remained unpaid effected a taking of property without just compensation and that such a taking is constitutionally prohibited no matter how great the public need. *Id.* at 602. The Court distinguished its approval of other moratorium measures, which resulted essentially in delaying mortgagees' remedies, as resting on the "assumption that no substantive right of the mortgagee was impaired, since payment in full of the debt with interest would fully compensate him." *Id.* at 581.

Accordingly, while in **Home Building & Loan Association v. Blaisdell,** 290 U. S. 398 (1934), the Court had approved a Minnesota statute which extended the period of redemption but, by providing for the payment of interest, taxes or rent, otherwise "[did] not impair the integrity of the mortgage indebtedness," in **W. B. Worthen Co. v. Kavanaugh,** 295 U. S. 56 (1935), it struck down an Arkansas statute which extended the redemption period and permitted the mortgagor to retain possession without providing the mortgagee continued consideration for his forbearance. The Court distinguished **Worthen** from **Blaisdell** on the ground that only the Minnesota statute involved in **Blaisdell** contained restrictive conditions which safeguarded the substantive interest of the mortgagee in protecting his investment. *Id.* at 63.

In its most recent decision in this area, **El Paso v. Simmons,** 379 U. S. 497 (1965), the Court did not rely on the traditional distinction between substantive and procedural rights in permitting the state of Texas to vary, by statute, thirty year old contracts for the purchase of public lands which had permitted defaulting property owners an unlimited period of redemption. The Court stressed, however, that the power of a state thus to modify or effect the obligation of contracts is not without limit, but must be construed in harmony with the fair intent of the constitutional limitation. *Id.* at 509. The Court then held consistent with this intent, the prospective five year statutory limitation which, with respect to forfeitures occurring thereafter, ". . . allowed defaulting purchasers with a bona fide interest in their lands a reasonable time to reinstate . . . [but] does not and need not allow defaulting purchasers with a speculative interest in the discovery of minerals to remain in endless default while retaining a cloud on title." *Id.* at 515.

In **Fornaris v. Ridge Tool Company,** 423 F. 2d 563 (1st Cir.), *rev'd. on other grounds* 400 U. S. 41 (1970), the Court of Appeals for the First Circuit relied on the Due Process Clause which it found to embody "essentially the same restraints [as the Contract Clause] so far as retrospectivity is concerned," *id.* at 566-67, to hold that, the police power notwithstanding, ". . . only minor infringements of established contractual rights may be effected without just compensation." *Id.* at 567.

In **Fornaris,** the case which the dissenting judge below found to be "most nearly on point" (409 F. Supp. at 830; J. S. App. A32), the Court of Appeals held unconstitutional as applied to contracts entered into before its passage, a Puerto Rican law which prohibited a manufacturer from terminating any dealership contract unless justified by a substantial failure of performance by the dealer. The Court of Appeals stated, (423 F. 2d at 567-68):

> ". . . No amount of research by parties or amici has discovered a case suggesting that to convert a contractual relationship terminable by either party without cause into one which, short of breach by the other party, can be terminated by one of the parties only by making substantial payments and without protection for its economic interests, is not a change of great magnitude." [8]

Accord, **Superior Motors, Inc. v. Winnebago Industries, Inc.,** 359 F. Supp. 773 (D. S. C. 1973); **Globe Liquor Co. v. Four Roses Distillers Co.,** 281 A. 2d 19 (Del.), *cert. denied* 404 U. S. 873 (1971).

The legislation condemned in **Fornaris** is directly analogous to Act 94 in its application to membership contracts presently in force but entered before its passage.

8. This Court reversed **Fornaris** on the ground that the state courts should be given an opportunity to construe the retroactive impact of the statute in a manner which might avoid the constitutional question. 400 U. S. 41 (1970).

Act 94 retroactively converts these from contracts terminable upon 90 days' notice to contracts which cannot be terminated for up to thirteen months, and then only after long and burdensome proceedings. In **Fornaris,** the Court of Appeals found the unanticipated costs of terminating the dealer contracts effectively to have increased the consideration paid by the manufacturers for the contracts. So here, the cost to the hospitals of the Blue Cross contracts covered by Act 94 is increased by the amount, over the thirteen months' extension period, by which the contractual rate of payment is less than the rate which the hospitals would otherwise be able to charge for services covered by the extended contracts. And, under Act 94, this amount can never be recouped, if a new contract is not signed.

The application of Act 94 to the Delaware Valley Hospitals is far more outrageous than the situation considered by the Court of Appeals in **Fornaris.** In the instant case, the contract revived by Act 94 had been performed and terminated sixteen months' before the Act was passed.[9] The same services sought to be placed by Act 94 under the coverage of the Delaware Valley Agreement were already within the ambit of separate contracts between the hospitals and their Blue Cross subscriber-patients. The hospitals had performed their obligations under these contracts, which called for the subscriber-patients to pay full charges, had billed the subscriber-patients for full charges in accordance with these contracts and, in most cases, had been paid.

As the majority below noted (409 F. Supp. at 822; J. S. App. A12), the impact of the retroactive provisions of Act

9. While the Delaware Valley Hospitals did not receive the right to begin collecting full charges from Blue Cross subscriber-patients until the "run-out" period commenced on August 15, 1974, the contract actually was terminated six months earlier on March 31, 1974, fully sixteen months before passage of Act 94 on August 2, 1975.

94 upon the Delaware Valley Hospitals was to require them to reach into their own pockets and refund money to which they had been lawfully entitled and to accept in exchange a right to collect a lesser amount from Blue Cross under the reinstated contracts. The practical effect of Act 94 is nicely illustrated by an example drawn from appellees' Motion To Affirm (pages 7-8). There, appellees demonstrate that a hospital which could, in a hypothetical case, recover $1,350 by billing a subscriber-patient directly for services provided by the hospital would be entitled to receive only $1,080 from Blue Cross under a membership contract for these same services. Thus, the effect of Act 94 upon the hospital in this hypothetical would be to require it to take a loss of $270 which had been lawfully charged and collected for services rendered as much as a year prior to Act 94's enactment.

Whether phrased in terms of the difference between substance and remedy or simply the degree of deprivation involved, Act 94 constitutes a constitutionally intolerable impairment of private contract rights.

This is not a case like any of those relied on by the majority below. It is not analogous to labor cases such as **Steelworkers v. United States,** 361 U. S. 39 (1959). The only right limited by Section 208 of the Labor Management Relations Act, 29 U. S. C. § 178, is the employees' right to strike. There is no limit on their right to leave their present employment and sell their labor for whatever it will bring in the open market. By contrast, the hospitals here are being **compelled** to provide service and at rates which are less than those to which they would otherwise be entitled. Nor is the minimum compensatory price of labor fixed by its component costs as is that of hospital services.

Neither does this case involve the kind of *de minimis* injury involved in **Day Brite Lighting, Inc. v. Missouri,** 342

U. S. 421 (1952). That case upheld the constitutionality of a state statute giving employees the right to take time from work to vote without loss of pay. As noted by the dissenting judge below, the financial burden which the **Day Brite** statute placed upon "the net return" from a business enterprise ". . . is a far cry from the plight of these nonprofit hospitals which contend they are being forced to operate at inadequate and confiscatory levels of reimbursement" (409 F. Supp. at 830; J. S. App. A31).

Nor is this a case like **Home Building & Loan Association v. Blaisdell,** *supra,* where the realization of substantive rights is delayed but not otherwise impaired by the legislative imposition of a staying period. Even if we put aside the reinstatement of terminated contracts, Act 94 does more than merely delay the hospitals' right of termination "without penalty" (Majority Opinion, 409 F. Supp. at 824; J. S. App. A16). If no new contract is negotiated, the hospitals cannot recoup the losses resulting from their being compelled to provide extended service under the limited reimbursement formula.

Finally, this is not a case like **Fleming v. Rhoads,** 331 U. S. 100 (1947), where the effect of the challenged legislation was merely to regulate future action based upon rights which had been previously acquired but which, in the absence of legislation, would not reach fruition until some time in the future. In **Fleming** the Court permitted an injunction against future evictions prohibited by the Price Control Extension Act of July 25, 1946, 60 Stat. 665, even though the landlords had obtained lawful state judgments during the one month hiatus between the time the original rent control act had terminated and the effective date of the Extension Act.[10] By contrast, in the case of the

10. Because the inadverent lapse in regulation was so brief, it might also be said that the parties in **Fleming** had legitimate expectations that rent controls would be reenacted. No such as-

Delaware Valley Hospitals, Act 94 reaches back to invalidate rights fully implemented and presumably binding a year prior to any legislative action. *See* Note, "Impairment of Contracts—Pyramid Sales Schemes—Remaining Limitation, If Any, On the Police Power Under the Contract Clause," 1976 B. Y. U. L. Rev. 280, 290 at n. 73.

Appellees have argued that the Delaware Valley Hospitals may not claim impairment of vested contract rights since they themselves had envisioned that any new contract with Blue Cross would apply retroactively to alter charges for the period prior to the negotiation of a new contract (Motion To Affirm at 19). In making this argument, appellees confuse voluntary modification of a legal right upon terms acceptable to the holder of that right with the forced surrender of rights by legislative decree. In any case, it is highly unlikely that the hospitals would have accepted a new contract which did not permit them to retain patient charges previously collected.

It is this aspect of Act 94—a reaching back into the past to redefine the contractual relationships between private parties and to redistribute the rights and obligations among them—which is so outrageous and so offensive to constitutional standards.[11] If the mere existence of a con-

10. (Cont'd.)
sertion is permissible in the instant case. Here, we have hospitals whose only contracts with Blue Cross subscribers were contracts which required the payment of full hospital charges. The hospitals were **not** parties to contracts whereby the subscribers purchased health insurance from Blue Cross.

Moreover, these hospitals have always negotiated with Blue Cross on a voluntary, arms' length, basis and could hardly be said to have legitimate expectations that, should they refuse voluntarily to enter a contract with Blue Cross for subscriber services, they would have the very same contract imposed upon them by legislative fiat sixteen months later.

11. As was stressed repeatedly below, despite the fact that Act 94's "Declaration of Necessity" purports to be responsive to the reasonable expectations of Blue Cross subscribers, implementation

tract at some time in the past is sufficient to bind a private party to continue in that relationship or be arbitrarily thrust back into that relationship at the whim of the legislature, this must produce the kind of economic instability and personal insecurity which the Contract Clause was intended to ameliorate. *See* **Sturges v. Crowninshield,** 17 U. S. (4 Wheat.) 120, 206 (1819).

II. THE COMMONWEALTH OF PENNSYLVANIA CANNOT CONSTITUTIONALLY COMPEL A PRIVATE NON-PROFIT HOSPITAL TO RENDER SERVICE UNDER A RATE FORMULA WHICH DOES NOT PERMIT THE HOSPITAL TO RECOVER ITS FULL COSTS OF DOING BUSINESS.

In the absence of Act 94, the Delaware Valley Hospitals had, and would continue to have, the right to charge Blue Cross subscriber-patients the full allocated costs of services provided them. Act 94 severely limited this right by requiring the hospitals to accept, on behalf of Blue Cross subscriber-patients only so much of the hospitals' charges as Blue Cross chooses to recognize under its "reasonable cost reimbursement" formula. Thus, regardless of whether or not the Blue Cross formula is reasonable or compensatory or otherwise justifiable, these hospitals suffered an impairment of contract rights and a deprivation of property to the extent that their preexisting legal rights were modified and reduced by the effect of Act 94.

Appellees have argued that, except with respect to the period from the original termination of the Delaware Val-

11. (Cont'd.)
of the "run-out" provisions insured that no subscriber was deprived of prepaid benefits. Moreover, any subscriber who renewed Blue Cross coverage after July 31, 1974, did so with full knowledge that Blue Cross would pay only non-member benefits in connection with claims for services provided by the Delaware Valley Hospitals, and did so in preference to purchasing commercial insurance which has been available at all times and provides indemnity coverage for full hospital charges.

ley Agreement until passage of Act 94,[12] Act 94 may be characterized as simply a piece of prospective rate regulation (Motion To Affirm at 10). Even viewed in this most favorable of all possible lights to appellees, the arbitrary selection by the legislature of what would have to be deemed the "rate formula" embodied in the Blue Cross contracts extended by Act 94 does not meet constitutional standards. Since it is clear that even fully-regulated public utilities may not be compelled to provide service at less than a fair rate of return, **Denver Union Stock Yard Company v. United States,** 304 U. S. 470 (1938), **D. C. Transit System, Inc. v. Washington Metropolitan Area Transit Commission,** 466 F. 2d 394 (D. C. Cir), *cert. denied* 409 U. S. 1086 (1972), certainly non-profit private hospitals may not be forced by the state to provide service under a rate formula which admittedly does not reimburse them their full costs of providing hospital services.

These fundamental principles of utility law were relied upon by the Court of Appeals for the First Circuit in **Mora v. Mejias,** 223 F. 2d 814 (1st Cir. 1955), to invalidate legislation fixing a maximum wholesale price for rice which was less than the price the plaintiff-importers had paid for the rice currently in stock. Conceding the importance of the price control measure to the economic welfare of the country, *id.* at 817, the Court of Appeals nonetheless found the importers in a position "analogous to that of a public utility which is required to devote its property to the service of the public." *Id.* at 818. Accordingly, it held that

12. With respect to this period, the impairment of vested rights effected by Act 94 is rendered more oppressive by the fact that the contractual rate of payment thereby imposed is not even compensatory. However, at least insofar as Act 94 purports to undo contractual relations fully and lawfully completed as much as a year earlier, the repugnance of Act 94 to both the Contract and Due Process Clauses is independent of the reasonableness of the rate of payment under the reinstated contract.

the plaintiffs could not be compelled to sell their rice at a loss. *Ibid.*

As in **Mora,** the legislature in the instant case has fixed a retail price for a product—here, hospital services—which does not allow recovery of all the costs which have gone into producing that product. While presumably relying on the market mechanism to determine a fair retail price, the legislature as much as conceded that there is a discrepancy between a fair retail price and the one imposed by virtue of Act 94 when it provided that the contract rates revived and extended by Act 94 are, themselves, subject to revision (but only *if* a new contract is negotiated).

It is a fundamental fact that if the rates imposed under Act 94 were applied generally to all private paying patients, appellant hospitals could not remain financially solvent (Supplemental Affidavit of Joseph A. Williamson, ¶ 17, A. 117-18, and affidavit of Edward J. Armstrong, ¶ 15; A. 74-5). The majority below steadfastly avoided coming to grips with that fact.

In its first attempt at answering appellants' contention that the "rate formula" imposed by Act 94 is confiscatory, the majority below stated that "[t]he validity of such ["reasonable cost reimbursement"] clauses in Blue Cross Hospital contacts has already been upheld" in **Travelers Insurance Co. v. Blue Cross of Western Pennsylvania,** 481 F. 2d 80 (3d Cir. 1973) (409 F. Supp. at 824; J. S. App. A16).

However, **Travelers** simply is not relevant to the issues presented here. **Travelers** involved claims by a private insurer that contractual price concessions granted Blue Cross of Western Pennsylvania by its member hospitals were obtained by conduct violative of the antitrust laws. The court held that whatever "economic inducements" were offered by Blue Cross to make its contract acceptable to the hospitals did not constitute "coercion" as that term

is used to limit the protection of the insurance exemption from the antitrust laws. 481 F. 2d at 84.

Travelers does not speak to the question of whether the Blue Cross contract was fair or compensatory, far less to the question of whether a state may constitutionally compel hospitals to work under such a contract. In fact, if **Travelers** has any meaning here, it is that a private party may voluntarily choose to enter a contract which, on its face, appears to be oppressive. Thus, the fact that appellant hospitals voluntarily entered the Delaware Valley Agreement in 1971 is legally irrelevant to the question of whether the payment formula contained in that agreement and, according to appellees, adopted as a "rate formula" by the Pennsylvania legislature, is compensatory.

The majority below next declared that because Blue Cross does not require appellant hospitals to undertake those expenses such as indigent patient care and bad debts which Blue Cross refuses to recognize as "reasonable costs," "plaintiffs have failed to show that the expenses incurred by plaintiffs under Act 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement" (409 F. Supp. at 826; J. S. App. A21).

There are at least two answers to this. In the first place, it is not at all clear that Blue Cross does not indirectly require the hospitals to provide those same services which it later refuses to reimburse.

Section 23 of the 1971 contract (Exhibit 17; A. 176a) provides that each hospital "agrees to strive for accreditation by the Joint Commission on Accreditation of Hospitals" and that, if a hospital is not so accredited, Blue Cross shall have the right upon twenty days notice to terminate the agreement. The *Accreditation Manual for Hospitals* adopted by the Joint Commission in 1970 and updated in

1973 embraces in its preamble the ideal of community service and notes explicitly that "no person should be denied impartial access to treatment or accommodations which were available and medically indicated, on the basis of such considerations as . . . the nature of the source of payment for his care." In other words, the hospitals would have no right to turn away a patient or limit medically required treatment because the only source of payment for that treatment would be from extremely limited public assistance grants which would leave the great bulk of the cost to be recovered from charges to be allocated private patients. Thus, in requiring conformity to accreditation standards, Blue Cross indirectly endorses the provision of indigent care in accordance with the above principle, the observance of which in practice is said to be "a persuasive factor in the determination of a hospital's accreditation, in the same manner as are any of the standards of this [accreditation standards] volume." [13]

And Blue Cross bears a great deal of responsibility for the substantial proportion of a hospital's costs of writing off bad debts which is attributable to patients who enter the hospital as Blue Cross subscribers and then have their coverage lapse during the course of their hospitalization. While Blue Cross does reimburse the hospitals for bad debts resulting from the failure of covered Blue Cross subscribers to pay the small coinsurance charges, this amount is relatively insignificant compared to the magnitude of uncollectible accounts for services rendered patients who had originally sought service in the status of Blue Cross

13. Hospital accreditation is also dependent on an institution's employment of a competent staff of medical personnel. In this context, it is worth noting that the uncharged services provided physicians' families—which again, Blue Cross refuses to recognize as "reasonable costs"—is part of the compensation paid by the hospital to professionals who are able to command much higher base salaries than those paid by most hospitals.

subscribers (Supplemental Affidavit of Joseph A. Williamson, ¶ 4; A. 113).

More fundamentally, it is strange indeed for the majority below to suggest, as a necessary condition to finding the Blue Cross reimbursement formula compensatory, that the hospitals could simply abandon costs necessary to the performance of their historic role as social and charitable institutions. A review of the historic development of the hospital as a social institution specifically refutes Blue Cross' contention that non-profit charitable institutions should not expect to recover from paying patients the costs of their charitable services (Motion To Affirm at 17, n. 14). While the European hospital was historically an institution endowed by the rich for the treatment of the poor, *see* H. Burdett, HOSPITALS AND ASYLUMS OF THE WORLD (1893) Volume III, American hospitals from the start tempered the charitable ideal with the principle that it was important to a patient's self-respect that he or she pay whatever he or she is able to pay. Accordingly, hospital charges in this country have always been variable, graded to the individual patient's income level. M. Risley, THE HOUSE OF HEALING (1961) at 226. *See generally* E. Churchill, "The Development of the Hospital" in the HOSPITAL IN CONTEMPORARY SOCIETY (N. Faxon, Ed., 1946).

Just such a glib solution as is proposed by the majority below was rejected by the First Circuit in **Mora,** *supra*. There, the Court of Appeals looked to the practical importance of rice in the Puerto Rican diet to hold that "application of the principle that the members of the industry could escape loss by withdrawing from the business of importing rice is not an honest answer to the question at issue." 223 F. 2d at 817.

The position of the majority below is quite inconsistent given that initially it justified Act 94 on the grounds

that hospitals are institutions affected with the public interest and that the presumed unavailability of hospital services is a crisis which would justify otherwise unconstitutional legislative intervention. Moreover, the majority's position is in conflict with the weight of judicial authority which, even in the regulatory field, has held that included among the legitimate costs of doing business are those associated with writing off bad debts, *see* 73 C. J. S., Public Utilities § 25 at 1041, and making charitable contributions which affect the utility's good will in the community, *see Annot.*, 59 ALR 3d 941 (1974).[14]

Ultimately, the majority seemed to give up its attempt to justify the Blue Cross reimbursement formula as nonconfiscatory and decided that it simply need not deal with this question which is "for the legislative process as distinguished from judicial inquiry" (409 F. Supp. at 825; J. S. App. A17). The majority further declared that Act 94 constituted a delegation of this question by the legislature to the Insurance Department. *Ibid.*

14. Blue Cross relies on the 1953 "Principles of Payment for Hospital Care" of the American Hospital Association (Exhibit 35; A. 417a-40a) as establishing a basis for the exclusion from the Blue Cross reasonable cost reimbursement formula (See Supplemental Affidavit of Bruce Taylor, ¶¶ 60-62; A. 120-21). While the AHA still maintains for accounting purposes that the costs of indigent care and bad debts should be considered as deductions from revenue rather than expenses, it insists that every purchaser of health care must pay a proportionate share of these costs. Thus, its more recent "Statement on the Financial Requirements of Health Care Institutions and Services" (Chicago, 1969) states (at 14):

> "Even with agreement as to the method of payment, negotiations could result in one or two contracting agencies paying less than their appropriate share because of their failure to accept all of the necessary elements of financial requirements. **Any negotiation which permits one or more contracting agencies to assume a lesser responsibility does not alter the total financial requirements of the Health Care Institution, rather it forces other payers to make up the deficiency.** It is for this reason that health care institutions should not permit any contracting agencies to pay less than their appropriate share."

However, the Insurance Department has no duty or authority under Act 94 to assure that payment under the extended or reinstated contracts is reasonable or compensatory. More importantly, the Insurance Department has no power independently to order any retroactive adjustment of payments. Rather, the Act provides only that, *if* a new contract is negotiated and approved by the Insurance Department, its terms shall apply retroactively to the date of termination of any prior agreement. Thus, even if the Insurance Department did find the contracts imposed by Act 94 to be confiscatory,[15] the most it could do would be not to exercise to the fullest its authority under Act 94 to suspend for up to thirteen months the hospital's right of termination. In other words, the Insurance Department has limited power under Act 94 to exacerbate the confiscatory impact of the imposed contracts, but no power to relieve it.

Nor does the Act itself evidence any considered or rational basis for the exclusion of identifiable items of expense from the reimbursement formula. There is no evidence that the Pennsylvania legislature ever considered underlying conditions in the health care industry. As the dissent below suggests, Act 94 was "an unfortunately hasty reaction" by the legislature to the complex problem spawned by the Blue Cross contract dispute (409 F. Supp. at 831; J. S. App. A33).[16]

15. The fact that the Pennsylvania Insurance Department was willing to approve a contract which included a 4% plus factor (Supplemental Affidavit of Paul I. Guest, ¶¶ 7-10; A. 100-07), suggests that it might well have found the 1971 contract to be noncompensatory.

16. Blue Cross, itself, has conceded in other contexts that it is hardly appropriate for the legislature to rely upon Blue Cross to formulate appropriate hospital rate schedules. Included in the statement made by Blue Cross' President, Bruce Taylor, in public

The statutory provisions, themselves, suggest that the legislature was aware that there was a discrepancy between the payment formula imposed by virtue of Act 94—which, if it had been the product of negotiations four years' earlier, had been resisted ever since by the hospitals as a basis for any new contract—and a formula which would reflect the present cost and value of hospital services. The legislature specifically provided that the rates imposed by Act 94 were not necessarily final rates. Rather, if a new contract were negotiated by the hospitals and Blue Cross its terms would be made retroactive to the date of termination of the preceding contract, thus recreating

16. (Cont'd.)
hearings before the Insurance Department on March 17, 1971, was the following (Exhibit 44; A. 455a-56a):

> "Second, Blue Cross regulation of hospital cost raises serious internal problems. Hospitals vary infinitely and general standards applicable to all cannot be fixed fairly. Differences in plant, in the type of cases, type of medical practice and many other factors affect their cost. To consider these multiple factors properly would require a major expansion of the Blue Cross staff.
>
> "Moreover, Blue Cross, even with an expanded staff, is not peculiarly fit for this decisional process. It has no expertise in many of these areas. Moreover, as the payor, Blue Cross decisions could be biased by its interest in reducing its own payments.
>
> "Third, decisions on most areas of hospital cost control will have profound influence on the entire health care delivery system. To suggest that such decisions should be exclusively in the hands of a single purchaser of health care is clearly foolhardy. Blue Cross personnel can claim no infallibility in this field, nor even special training where medical practice or hospital procedures are involved. Obviously, and without false modesty, this role should not be exclusively ours.
>
> "Fourth, legal authority is required to produce involuntary changes in the health care system as it exists today. . . .
>
> "Such uniformity can only come through governmental supervision based on law, and not the indirect pressure of changing Insurance Commissioners through a variety of Blue Cross entities."

the situation which could have existed had Act 94 never been passed. However, there is no rational reason why the rate formula imposed by virtue of Act 94 should constitute reasonable final rates for the effective period of the Act just because the hospitals fail to negotiate a new membership contract. Thus, the contingent provision for revising rates payable under Act 94 serves only to underline the arbitrariness of attempting to pluck a "rate formula" out of a private contract negotiated four years earlier.

Even if the majority were correct that the selection of a rate formula was a question originally for the legislative process, it is clear that where the legislature has failed to propose any rational or considered basis for its selection of a rate formula, it is for the courts to strike down such an arbitrary formula as improper. **Patterson Drug Co. v. Kingery,** 305 F. Supp. 821, 827 (W. D. Va. 1969); *cf.* **Nebbia v. New York,** 291 U. S. 502, 516 (1934). As demonstrated above, the formula incorporated by Act 94 is arbitrary and unconstitutional in that admittedly it requires the hospitals to provide service at rates which deny them recovery of their traditional and appropriate costs.

III. APPELLANTS ARE ENTITLED AT THE VERY LEAST TO A FACTUAL HEARING TO DETERMINE WHETHER THE CONTRACT RATES IMPOSED BY ACT 94 ARE CONFISCATORY.

Even if we assume *arguendo* that Act 94 is not unconstitutional on its face, it was nonetheless improper for the court below to have granted summary judgment to defendant-appellees. At the very least, appellant hospitals are entitled to a full hearing at which they will be given an opportunity to prove the confiscatory effect of the reimbursement formula as applied to individual fact situations. As Judge Luongo pointed out in his dissent, even if appellants' affidavits are not conclusive, they at

least raise material issues of fact sufficient to withstand appellees' motion for summary judgment (Dissenting Opinion, 409 F. Supp. at 829, n. 1; J. S. App. A29).

The majority opinion seems to have been written under the misapprehension, fostered by Blue Cross, that the hospitals are regulated entities. For example, at paragraph 57 of his Affidavit, the President of Blue Cross states (A. 94):

> "57. In sum, the Pennsylvania Plans, lacking direct governmental authority to limit hospital cost, have traditionally negotiated cost limitations and quality controls into their contracts with Member Hospitals. These controls are the product of collective bargaining and represent a substantial value for Subscribers. The Pennsylvania Legislature recognizes the success that the Plans have achieved in this voluntary process and encourage this form of development by only indirectly regulating hospital rates, that is, through Insurance Department approval of hospital contracts. However, if this bargaining process is no longer viable, hospital rate setting regulation may be required."

While it is true that the Insurance Department has authority to approve transactions of hospital plan corporations including their contracts with member hospital, 40 Pa. C. S. § 6124, it is only to the extent that a hospital joins in the submission of such a contract for the approval of the Insurance Department that it is subject to any form of regulation by the Insurance Department or any other regulatory or administrative body.

Nonetheless, the majority below distinguished the decision in **Fornaris v. Ridge Tool Co.,** *supra,* on the ground that "their [the hospitals'] expectations as a regulated industry are different from those of the commercial manufacturers in **Fornaris**" (409 F. Supp. at 824; J. S. App. A16). Moreover, the majority analogized the effect of Act 94 which requires appellants to refund subscriber payments lawfully due and remitted prior to the enactment of Act 94 to "remedial measures in other regulatory statutes" as, for example, when carriers are required to "refund, with interest, increased rates found to be not justified" (409 F. Supp. at 825, n. 12 and accompanying text; J. S. App. A19).

What is most bizarre about this theory is that, if the hospitals were regulated in fact, they would have been afforded those fundamentals of due process—both procedural and substantive—which they have been denied here. One has only to look at the various bills which have been proposed by the Pennsylvania legislature for the regulation of the health care industry to see that, if appellant hospitals were in fact regulated, they would have been guaranteed an opportunity for prior hearing upon the reasonableness of the proposed rates and, of course, with the right to judicial review (See proposed bills collected at Exhibits 33 A-E; A. 334a-416a).

Implicit in the majority's assumption of regulation is the belief that there is some regulatory body required to take into consideration the interests of the regulated party and from which that party may seek relief from an onerous exactment. Thus, for example, the majority assumed that the Insurance Department was authorized to consider and adjust the adequacy of payment under the reinstated contracts. However, while Act 94 does provide for hearings before the Insurance Department, the right to be heard means little since, as noted above, the Insurance Department has no authority to alter the rate of reimbursement under the Blue Cross contract or to require Blue Cross to agree to a compensatory contract in the future.

The legislature, on the other hand, never bothered to provide the hospitals an opportunity to comment on the reasonableness of the Blue Cross reimbursement formula before it was imposed upon them by virtue of Act 94.

In effect, then, as a result of the scheme embodied in Act 94, the hospitals have been deprived of the right to protect their own interests by voluntary arm's length negotiations, without being accorded the due process attached to regulatory proceedings. Under these circumstances, they cannot, in addition, be deprived of the opportunity to a judicial hearing upon their claim that the contract rates imposed by Act 94 are confiscatory and unconstitutional as applied to their individual factual situations.

CONCLUSION.

For the reasons set forth above, the judgment of the United States District Court for the Eastern District of Pennsylvania should be reversed with directions to enter judgment and injunctive relief for appellants or, at the very least, to grant appellants a hearing on their contention that the rates imposed by Act 94 are confiscatory as applied to their individual factual situations.

Respectfully submitted,

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ADDENDUM.

Act 94 of the 1975 Session of the Pennsylvania Legislature (Act of August 2, 1975, P. L. 293, amending Section 6124 of Title 40 of the Pennsylvania Consolidated Statutes), provides as follows:

Section 1.

Section 6124 of Title 40, act of November 25, 1970 (P. L. 707, No. 230), known as the Pennsylvania Consolidated Statutes, added November 15, 1972 (P. L. 1063, No. 271), is amended by adding a subsection to read:

§ 6124. Rates and contracts

. . .

(c) Maintenance of contractual relationships.—

(1) Declaration of necessity.—It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be

subject to prior approval by the department as provided in this subsection.

(2) **Notification period.**—No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.

(3) **Hearing period.**—Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) **Negotiation period.**—If the department recommends terms for continuation of the contract, the

hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of the hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) **Retroactivity.**—Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2.

The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received

prepaid benefits on or after June 30, 1974 if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa. C. S. Chap. 61 (relating to hospital plan corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3.

This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

Approved the 2nd day of Aug. A.D. 1975.

Supreme Court, U. S.
FILED
DEC 22 1976
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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Counterstatement of Questions Presented

[Questions in Nos. 75-1691 and 75-1698]

The following three questions are presented by the appeals in both No. 75-1691 and No. 75-1698:

1. May a State, consistent with the Due Process and Contract Clauses of the Constitution of the United States, prescribe as temporary hospital service charges or rates, for a period not exceeding 10 months (13 months on a transitional basis), the rates previously in force, where at the expiration of such temporary rate period each affected hospital may exercise an unrestricted right to fix its rates for hospital services thereafter furnished at whatever level it may deem appropriate to recoup any deficiency in income caused by the action of the State in fixing temporary rates?

2. Assuming *arguendo* that notwithstanding the ability to effect recoupment at the end of the temporary rate period, a State must insure that any temporary hospital service rate level fixed does not fall below the zone of reasonableness and become confiscatory, is a cost-of-service formula constitutionally permissible which expressly covers all direct costs of the services furnished and a proportionate portion of joint costs (including depreciation of capital assets), but which excludes subsidization of indigent patient expenses, accumulations for the future purchase of equipment, research costs and other expenditures not necessary to

the furnishing of the hospital services for which the challenged temporary rates have been established?

3. Was the District Court correct in concluding that the issue of alleged confiscation by a statutory temporary rate formula could be resolved by an examination of the cost-of-service nature of the formula itself, without the need for a *de novo* trial in the nature of a public utility rate case?

[Questions in No. 75-1691 only]

The following two questions are presented by the appeal in No. 75-1691:

4. When a group of hospitals have repeatedly followed the practice during inter-contract intervals of treating the financial arrangements which they make with discharged Blue Cross subscribers as provisional and subject to complete recharacterization (both as to identity of parties and basis of payment) upon the execution of a succeeding Blue Cross-hospital contract, are such arrangements sufficiently fluid to permit a State constitutionally to impose price regulation thereon?

5. Assuming *arguendo* that the Contract and Due Process Clauses are applicable to price regulation by a State of the inter-contract interval arrangements between a hospital and Blue Cross subscribers, may a State extend the reach of its 10 month (13 month) temporary rate procedures retroactively for varying

periods of up to 11½ additional months so as to close a newly-opened gap in a 38-year old scheme of regulation and eliminate invidious discrimination among Blue Cross subscribers whose subscription agreements terminate at different times during the inter-contract interval?

[All questions to be answered in the Affirmative]

Counterstatement of the Case

The Blue Cross-Subscriber Contract. As indicated in the record (A.77-78 ¶¶ 3-4)[1], Blue Cross plans were established by the hospital industry itself as a mechanism to pre-pay the costs of hospital service. See also *Travelers Ins. Co.* v. *Blue Cross of Western Pa.*, 361 F. Supp. 774, 779 (W.D. Pa. 1972).

A potential hospital patient enters into a subscription contract with a hospital plan corporation (hereinafter a "Blue Cross Plan" or a "Plan"). Under the typical subscription agreement the Blue Cross Plan agrees to provide one of two alternative types of benefits.

Under the more usual arrangement, the Plan will obtain hospital services for the subscriber in a so-called "member hospital". In some cases the subscriber must pay a relatively small portion of the hospital bill as coinsurance. In other cases the full hospital service is provided by the Plan, and no payment is made by the subscriber in connection with a spell of hospitalization. The benefit under this alternative is referred to as a "service benefit" (A.80-88 ¶¶ 10-19).

Where the subscriber is admitted to a hospital which is not a "member hospital", the Plan merely makes a cash payment directly to the subscriber in whole or partial reimbursement of his or her cost of hospitalization. Typically, this payment will be much less (amounting in some cases to only about 10% of the charges) than the full hospital charge. The benefit under this alternative is referred to as an "indemnity benefit" (A.83-84 ¶ 20).[2]

[1] References to "A." are to the single Appendix. References to "Ex." are to the separate volume of Exhibits to Appendix. References to "J.S." are to the Jurisdictional Statements of appellants.

The Blue Cross-Hospital Contract. There is no need for a Blue Cross Plan to have any contractual relationship with hospitals in a community in order to provide the indemnity benefit, which, as indicated above, is paid directly to the patient-subscriber. To provide the more comprehensive service benefit, however, a second class of contract is necessary, *i.e.*, between the Blue Cross Plan and the hospitals in a community (see A.80-81 ¶¶10-12). It is of major significance to this litigation that historically almost all major hospitals in Pennsylvania have been member hospitals contracting with Blue Cross (see A.83 ¶ 19). Indeed, until the recent defection of the hospital appellants in No. 75-1691 (the Delaware Valley Hospital Council-represented hospitals), litigation had arisen in exactly this direction, *i.e.*, appellee Blue Cross of Greater Philadelphia has been made a defendant for allegedly improperly refusing to admit a hospital to the widely desired status of member hospital. See, e.g., *Doctors*

[2] Appellants in No. 75-1698 incorrectly state (J.S. 19) that "(n)on-member hospitals, treating Blue Cross subscribers, receive a predetermined amount from Blue Cross." In point of fact, only "member hospitals" have a direct relationship with Blue Cross; in a "non-member hospital" admission, the Blue Cross payment is made to the subscriber, *not* to the hospital.

Hospital v. *Blue Cross of Greater Philadelphia*, No. 73-1057 (E.D. Pa. August 13, 1975), *aff'd per curiam*, No. 75-2166 (3rd Cir. April 28, 1976).

Transmutation of the Blue Cross-Hospital Contract into a Hospital Cost Containment Tool. The initial authorization for the creation of Blue Cross Plans in Pennsylvania was given by the enactment of the Nonprofit Hospital Plan Act, act of June 21, 1937 (P.L. 1948) and the companion act of June 21, 1937 (P.L. 1980), which amended the Nonprofit Corporation Law of 1933 to permit nonprofit hospitalization plans to be incorporated under the Nonprofit Corporation Law notwithstanding their regulation by the Insurance Department. These provisions are now codified at 40 Pa. C.S.A. §§6101-6127.

Generally speaking, the laws applicable to commercial insurers are not applicable to Blue Cross Plans. 40 Pa.C.S.A. §6103(a). A Plan may contract only with government-operated hospitals or with hospitals approved by the Department of Public Welfare. 40 Pa. C.S.A. §6121; 62 P.S. §1103;[3] 67 Pa.C.S.A. §6102; 71 P.S. §755-2. Blue Cross-hospital and Blue Cross-subscriber contracts are subject to Insurance Department approval. 40 Pa.C.S.A. § 6124(a). See generally *Insurance Department* v. *Saint Lukes Hospital of Bethlehem*, 342 A.2d 773 (Pa. Comm. Ct. 1975) (upholding in part refusal of Insurance Department to approve hospital contract submitted by Blue Cross of Lehigh Valley).

[3] Pennsylvania is undergoing a statutory codification program similar to the Revised Statutes. Codified provisions are cited as "Pa.C.S." (official version) and "Pa.C.S.A." (West's annotated version). Uncodified provisions are available only in West's unofficial *Purdon's Pennsylvania Statutes Annotated*, cited herein as "P.S." The distinction is operative and not merely formal, *e.g.*, 15 P.S. § 102 refers to a 1925 Act relating to acknowledgments, while 15 Pa.C.S.A. § 102 (which appears in a pocket part to another volume) refers to the definitions applicable generally to Title 15 of the new official codification.

Originally, the Blue Cross-hospital contracts called for Blue Cross to pay a flat per diem reimbursement to a hospital in order to purchase the hospital service required by a subscriber-patient. See *Travelers Ins. Co.*, *supra*, 361 F. Supp. at 778.

As successive Pennsylvania Insurance Commissioners began to appreciate the significance and magnitude of hospital cost inflation, a governmental policy was adopted to utilize the Blue Cross-hospital contract as a vehicle to control the rate of escalation of hospital costs (A.84-86 ¶¶ 21-28). This technique was feasible because over half the population of the Commonwealth of Pennsylvania is covered by Blue Cross benefits and, as noted earlier, almost all major hospitals in Pennsylvania contract with Blue Cross (A.79, A.83 ¶¶ 6, 19).

Accordingly, the Blue Cross-hospital contracts were revised in several stages until by 1971 the hospitals no longer received from Blue Cross a flat per diem reimbursement (which had always been less than the hospital's posted "charges" (or retail price)), but rather received only the actual cost (including depreciation

of capital assets) of providing the service to Blue Cross subscribers (A.84 ¶¶ 23-24). See also *Travelers Ins. Co., supra*, 361 F. Supp. at 778-79. These Blue Cross-hospital contracts are complex, but in general provide definitions of reimbursable costs and procedures for the resolution of disputed questions, including, where necessary, ultimate court review.

The Unanticipated Abandonment of Member Hospital Status by the Delaware Valley Hospital Council. The Delaware Valley Hospital Council (the "DVHC"), appellant in No. 75-1691, represents a group of approximately 30 hospitals which have since August 15, 1974[4] refused to extend voluntarily their Blue Cross-hospital contracts (contracts which have existed, in one form or another, since the inception of the Plan in southeastern Pennsylvania in the late 1930's). It is anticipated on all sides that any new contract, like all prior contracts, will take effect retroactively to August 15, 1974 (A.91 ¶ 47; Ex. no. 29).

The effect of the August 15, 1974 "termination" of the Blue Cross-hospital contracts was gradually to convert the DVHC hospitals from "member" to non-member hospitals over the period of a year. Under the

[4] Appellants in No. 75-1691 have variously asserted that the expiration date was June 30, 1974 (A.9 ¶ 9) or March 31, 1974 (Brief at 8). However, as the District Court expressly found (409 F. Supp. at 820; J.S. in No. 75-1691 at A6), appellants had agreed to an extension to August 15, 1974 (see Ex. 288a ¶ 5). Appellants are apparently straining to avoid the August 15, 1974 date because their contract with appellee Blue Cross therefore did not fully expire until August 15, 1975, *after* the enactment of Act No. 94.

so-called "run-out" provision of the contracts (see Ex. no. 23), the DVHC-represented hospitals were to lose their status as "member" hospitals with respect to any particular Blue Cross subscriber on the next annual renewal date of his or her Blue Cross-subscriber contract. Thus a progressively declining proportion of all Blue Cross subscribers were entitled to ""member" benefits in DVHC-represented hospitals, with the last group scheduled to lose such benefits on August 15, 1975 (one year after the commencement of the run-out period). The effect of this change is illustrated by the following hypothetical example:

Before the run-out, a Blue Cross subscriber who experienced a 9-day spell of hospitalization in a "member" hospital with a $150 per day rate[5] and a $120 per day "cost"[6] might have been presented on discharge with a $90 bill computed as follows:

Hospital "charges"	$150 per day
Cost of service as determined under the Blue Cross-hospital cost reimbursement formula	$120 per day

[5] Appellants suggest that the hospitals' list prices or "charges" may be as much as 40% more than their "reasonable costs" (Brief in No. 75-1691 at 7, Brief in No. 75-1698 at 3, 9), but a 25% profit or markup is utilized here for illustrative purposes.

[6] During the period involved the per diem "cost" rate in the DVHC-represented hospitals was in the range of $85 to $140 (Ex. no. 23, Ex. 288a-289a. See also Ex. no 31).

Paid by subscriber to hospital (required coinsurance under Blue Cross-subscriber contract) (9 x $10)[7]	$90
Paid by Blue Cross to hospital .....(9 x $120) — $90 =	$990
Total received by hospital	$1,080

After the run-out, the impact on the Blue Cross subscriber could be dramatically different, since the nonmember status of the hospital converts the Blue Cross program to a cash indemnity plan, and the hypothetical patient would be presented on discharge with a $1,350 bill:

Hospital "charges"	$150 per day
Paid by subscriber to hospital (9 × $150)	$1,350
Indemnity paid subsequently by Blue Cross to subscriber (1 × $50 + 8 × $25)[8]	$250
Net amount ultimately paid by subscriber	$1,100

Policy Options Available to the General Assembly. Faced with the unanticipated refusal of a sizable group of hospitals to agree voluntarily to charge no more than "cost" as defined in the last Blue Cross-hospital contracts approved by the Insurance Department (Ex.

[7] See, *e.g.*, Co-Pay Preferred Comprehensive Subscription Agreement, Article I, section 2 (Ex. 83a).

[8] See, *e.g.*, Co-Pay Preferred Comprehensive Subscription Agreement, Article I, Section 4A (Ex. 86a).

nos. 17, 18, 20 and 23), and with the lapse of the related regulatory requirements of such contracts, the General Assembly was faced with, *inter alia*, the following choices:

a. The creation of a permanent full-blown hospital regulatory scheme patterned after the Milk Control Board or the Pennsylvania Public Utility Commission (see Ex. no. 33A);

b. Authorize and require the Insurance Department on a permanent basis to fix the amounts which hospitals may charge Blue Cross or Blue Cross subscribers for Blue Cross subscriber admissions and to impose regulatory requirements similar to those contained in the lapsed contracts; or

c. Rely on the voluntary negotiation of Blue Cross-hospital contracts subject to Insurance Department approval, but strengthen the participation of the Insurance Department in the negotiating process as a permanent change and seek to "patch up" the up to 11½ month hiatus in regulation by prescribing as to this "locked-in" period cost-based rates on a formula which had been approved originally by the affected hospitals and which would be automatically superseded retroactively by any voluntary settlement which Blue Cross and the affected hospitals might, with the approval of the Insurance Department, elect to make.

Response of the General Assembly to the Problem. Eschewing the more radical solutions, the General As-

sembly opted for the minimum level response. On August 2, 1975, *prior* to the August 15, 1975 final run-out of the then existing Blue Cross-hospital contract with the DVHC-represented hospitals, it enacted Act No. 94. The Act has the following effects:

a. Where a Blue Cross-hospital contract was in existence on August 2, 1975, or where it is entered into then or thereafter, the contract (including primarily the cost reimbursement feature) may not thereafter be terminated without going through a "cooling-off" procedure involving notice to the Insurance Department, investigative hearing, recommendations by the Department, and further negotiations. (This is the only concern of the appellants in No. 75-1698, since they were in no way directly involved in the dispute between Blue Cross and the DVHC-represented hospitals, but had existing contracts which became subject to the mediation and cooling-off provisions of the statute.)

b. The remaining impact of the statute was confined to hospitals which had benefited substantially continuously from Blue Cross-hospital contracts during the *ten year* base period June 30, 1964 to June 30, 1974, but which were not covered (except for the application of the run-out period) by a Blue Cross-hospital contract on August 2, 1975 (all of the DVHC-represented hospital appellants in No. 75-1691 fall into this classification). As to these hospitals the last

approved Blue Cross-hospital contract on file with the Insurance Department was made applicable to August 2, 1975 and subsequent hospital admissions until a termination of the prior contract under the mediation and cooling-off provisions described in (a) above was effected, or unless and until the prior contract was retroactively superseded by a new agreement, voluntarily entered into between Blue Cross and the hospitals and approved by the Insurance Department.

c. In the case of hospitals covered by (b) above, the last approved Blue Cross-hospital contract was also made applicable to the operations of the hospitals during the "locked-in" period between August 15, 1974 and August 2, 1975, unless and until retroactively superseded by a new voluntary agreement as described in (b) above.

Act No. 94 could, of course, have been drafted simply to say that "cha.ges" for Blue Cross subscribers would be limited to those produced by the last approved reimbursement formula, without any language purporting to "reinstate" the expired contract. However, under the Blue Cross-subscriber agreements, unless the Blue Cross-DVHC contracts were technically reinstated the DVHC hospitals would have lost their status as "member hospitals." Had this occurred, many Blue Cross subscribers who were admitted to the DVHC hospitals would have received only the lower indemnity benefit (*e.g.*, per-

haps only 25% of the actual per diem charge), rather than the complete or almost complete service benefit; and subscribers would have been entitled to demand direct payment of the benefit check from Blue Cross, resulting in a dispersal among many individuals of funds which from a health delivery system point of view should be delivered in bulk by Blue Cross to the hospitals, and further requiring the hospitals to seek out the discharged Blue Cross subscribers to collect the amounts due the hospitals.

Returning to the earlier hypothetical example, if Act No. 94 had been drafted simply as a price control statute, the Blue Cross subscriber who expected to pay $90 on discharge would still have found it necessary to pay a net of $830 for his or her spell of hospitalization:

Hospital "charges" before controls	$150 per day
Hospital "charges" as determined under Blue Cross-hospital cost reimbursement formula adopted by Act No. 94	$120 per day
Paid by subscriber to hospital ($9 \times \$120$)	$1,080
Indemnity paid subsequently by Blue Cross to subscriber ($1 \times \$50 + 8 \times \$25$)	$250
Net amount ultimately paid by subscriber	$830

By characterizing the Blue Cross-hospital contract as "reinstated," Act No. 94 gave the DVHC-represented

hospitals "member hospital" status under the separate Blue Cross-*subscriber* contracts, thus, in the hypothetical example, restoring the Blue Cross-paid portion of the hospital bill to $990 from $250 and reducing the subscriber-paid portion from $830 to $90.[9]

Court proceedings. The appellants alleged in their amended complaint (A. 32 ¶ 9) that the action was brought by the named plaintiffs as, *inter alia*, representatives of a class as defined in Fed. R. Civ. P. 23. No order certifying class action status was ever entered below, and the opinion of the District Court does not contain the class findings required by Rule 23(c)(3).

In Count II of their amended complaint in the District Court (A. 36-37), appellants originally challenged Act No. 94 on the grounds that the Act is unconstitutional under the Equal Protection Clause as applied to Blue Cross-hospital contracts entered into after August 2, 1975. The equal protection rights asserted were those of commercial insurers, not those of any of the appellants. The District Court noted that this issue had been resolved by the Third Circuit in *Travelers Insurance Co.* v. *Blue Cross of Western Pa.*, 481 F.2d 80 (3rd Cir. 1973), *cert. denied*, 414 U.S. 1093 (1974), and both the majority and the dissenting judge below held that Act No. 94 in its prospective application is fully constitutional. In this Court,

[9] Throughout the balance of this Brief, all financial examples will be based on the hypothetical examples set forth herein.

appellants have abandoned their equal protection attack on the statute as well as their attack in respect of application of the statute to Blue Cross-hospital contracts entered into after August 2, 1975. Therefore, in this Court appellants are aligned as follows:

No. 75-1691 (*Guest et al.* v. *Fitzpatrick et al.*). Appellants in this appeal are the DVHC, the DVHC hospitals and related officials, who challenge Act No. 94 insofar as it reinstated the 1971-1974/75 Blue Cross-DVHC contract.

No. 75-1698 (*Williamsport Hospital et al.* v. *Fitzpatrick et al.*). Appellants in this appeal are Williamsport Hospital and The Hospital Association of Pennsylvania, who challenge Act No. 94 insofar as it imposes cooling-off and mediation procedures with respect to Blue Cross-hospital contracts existing on August 2, 1975. (Presentation of this issue by appellants in No. 75-1691 would obviously pose an embarrassing dilemma for them, since those appellants argue that they had no contract with Blue Cross on August 2, 1975, notwithstanding the fact that they had previously agreed that their existing contract would continue until August 15, 1975 as to certain Blue Cross subscribers.) The amended complaint (A. 32 ¶ 8) contains a vague statement that could be read as alleging that Act No. 94 operated to reinstate the Blue Cross-hospital contracts of unnamed hospitals (other than the DVHC group). No such hospital was ever identified on the record; appellants have not presented in their

Jurisdictional Statement any question relating to reinstatement of contracts; and appellees are not aware of the existence of any such reinstated contracts.

SUMMARY OF ARGUMENT

The unanticipated refusal of the principal group of hospitals in southeastern Pennsylvania to continue to provide hospitalization services under a 38-year-old program originally developed by the hospitals, and upon which over half of the affected population had come to rely, created an emergency condition with which the Pennsylvania General Assembly could constitutionally deal under the Commonwealth's police powers.

Insofar as Act No. 94 subjects appellants in No. 75-1698 to the strictures of a 10 month cooling-off and mediation period as a precondition to the cessation of services pursuant to the terms of contracts in existence on the date of enactment of the Act, the legislative response is merely an application of well-established principles developed in the context of the police regulation of the cessation of services by individuals. For example, at least since the decision of this Court in *Wilson* v. *New*, 243 U.S. 332 (1917), it has been clear that the police power may be used to require individuals providing essential services to the public to continue to provide such services during a statutorily-defined cooling off and mediation period, notwithstanding private contract provisions contemplating the cessation of such services as a bargaining tool or otherwise. Given the 38-year life of the existing Blue Cross-hospital program, the pattern of prior retroactive contract settlements and the public's justifiable reliance on a continuation of such pattern, and the institutional nature of the affected providers of the health services, there was clearly a rational basis for extending the mediation and cooling off principle to Pennsylvania hospitals who contract with Blue Cross.

Appellants repeated assertion that the statutory procedure does not contemplate (short of voluntary retroactive settlement of a disputed contract negotiation) recoupment from patients admitted and charged regulated rates during the cooling-off period is true but constitutionally irrelevant. The relevant and controlling fact is that after the cooling-off period expires (without voluntary retroactive settlement) the hospitals are wholly free of regulation and may effect all needed recoupment by temporarily or permanently adjusting upward their charges for post-cooling off admissions. This procedure has long been regarded as constitutional in other applications of State price regulation, since it merely shifts the time period during which the disputed fraction (here approximately 3% of the base charge) of earnings is received, and does not purport to deny it permanently.

Appellants compare apples with oranges since they contend that free care and other disputed items must be allowed as an expense, but overlook the fact that gifts, endowment income and other items are not recognized as income under the statutory formula. In any event the level of the temporary rates involved here is

clearly nonconfiscatory as a matter of law, since the rate formula (which is essentially the Medicare formula) is general in nature, expressly provides for the reimbursement of all costs applicable to the services provided to Blue Cross subscribers, and provides for judicial review of specific disputes. The Constitution does not require that Pennsylvania fund medical services for indigents through a regressive surcharge on Blue Cross premiums (which are collected on a per capita basis) rather than through its general income tax or other taxes, or that Pennsylvania choose commission-type hospital regulation over other alternatives.

The considerations outlined above are also directly applicable insofar as Act No. 94 subjects appellants in No. 75-1691 to the observance of temporary rates for the post-enactment period.

Insofar as the August 15, 1974 through August 2, 1975 locked-in period is concerned, the appellants in No. 75-1691 cannot rely upon the Contract Clause because their contracts with their patients never became "vested" in the constitutional sense, as they were highly tentative only, to be abandoned in favor of service contracts with Blue Cross upon the expected completion of the current contract negotiations.

Furthermore, on this record Pennsylvania was entitled to take the action which it did to eliminate the unanticipated and patently dangerous hiatus in the established system for delivering hospital services to a

substantial part of the population of the affected area and to eliminate invidious discrimination among Blue Cross subscribers who required hospitalization during the hiatus period.

ARGUMENT

I: TO BE VALID UNDER THE APPLICABLE CONSTITUTIONAL STANDARDS, IT IS REQUIRED ONLY THAT THERE BE A RATIONAL BASIS FOR THE STATUTORY RESPONSE OF THE PENNSYLVANIA LEGISLATURE TO THE HIATUS IN HOSPITALIZATION REGULATION CAUSED BY THE UNEXPECTED REFUSAL OF CERTAIN HOSPITALS TO SUBMIT NEW BLUE CROSS-HOSPITAL CONTRACTS TO THE PENNSYLVANIA INSURANCE DEPARTMENT FOR REGULATORY REVIEW AND APPROVAL.

Act No. 94 is a measure for the compulsory regulation of hospital rates and practices, enacted because of the emergency conditions existing in Pennsylvania due to the unanticipated break-down in the technically voluntary Blue Cross reimbursement and review system. Thus, the General Assembly in enacting Act No. 94 made a specific declaration of necessity:

> "It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. [10] It is hereby declared to be

[10] In an effort to avoid the thrust of this legislative finding, appellants in No. 75-1691 attack the Act as "outrageous" (Brief at 25) and all appellants urge that Blue Cross coverage is merely term insurance which creates no expectation of continued service in the local hos-

(footnote continued on following page)

> essential for the maintenance of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the [Pennsylvania insurance] department as provided in this subsection." 40 Pa. C.S.A. § 6124(c)(1).

In assessing the validity of Act No. 94, a distinction must be drawn between the standards of review in respect of State economic regulation and State infringement of civil rights and liberties. Legislation touching on individual freedoms, and especially First Amendment freedoms, is subject to an exacting judicial review. Regulatory legislation as to economic matters, on the other hand, "is not to be pronounced unconstitutional unless in the light of the facts made known or generally assumed it is of such a character

pital. The only thing "outrageous" in this case is the smug assertion by the hospitals to the effect that after a Blue Cross subscriber has paid premiums for years, and perchance has acquired a serious or even terminal condition, he or she should go out and purchase commercial insurance "which has been available at all times" (Brief in No. 75-1691 at 26 n. 11). Obviously, there is no record citation in appellants' brief for this amazing and callous assertion.

as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators." *United States* v. *Carolene Products Co.*, 304 U.S. 144, 152 (1938).

The theoretical basis for this bifurcated standard of review has been perhaps best stated by Mr. Justice Brandeis: "To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (dissent). Viewed historically, this broader discretion permissible in respect of economic matters represents a reversal of the early standards for constitutional adjudication; as Professor Freund has put it,

> "there has been a Copernican revolution since the late nineteenth and early twentieth century: whereas formerly the Court (always over the dissents of some of its most respected members) was quick to strike down novel measures of economic and social reform in the name of due process of law and was slow to assimilate the First Amendment freedoms into the Fourteenth, today no real barrier is raised against legislative experiments in the economy but very severe obstacles face legislative restrictions on the launching of ideas." Paul A. Freund, *The Supreme Court of the United States* 24 (1961).

Thus, in assessing matters of economic regulation, this Court today does not sit as a superlegislature, requiring agreement with its own notions of policy. *Ferguson* v. *Skrupa*, 372 U.S. 726, 731-32 (1963). Rather, deference is granted to State legislatures and the Congress to reconcile conflicting interests within a broad zone of reasonableness.

Act No. 94 is, of course, a somewhat specialized type of economic regulation. That is, Act No. 94 is in operation and effect ratemaking legislation.[11] To recognize this fact, however, is not to turn a hospital into a public utility. At least as early as 1934 this Court recognized that the power of a legislature to impose rate regulation does not depend on utility status. See *Nebbia* v. *New York*, 291 U.S. 502 (1934). Indeed, the Natural Gas Act subjects producers of natural gas to a highly articulated scheme of rate regulation, and this Court has read that Act quite expansively while at the same time recognizing that "(p)roducers of natural gas cannot usefully be classified as public utilities." *Permian Basin Area Rate Cases*, 309 U.S. 747, 756 (1968).

[11] It is of course clear that in this Court the validity of Act No. 94 is to be tested by its substantive operation and effect as ratemaking legislation, so that the contract law "aura" in the statutory reinstatement language is not controlling. See *Lavine* v. *Milne*, 424 U.S. 577, 584 (1976).

For the reasons discussed below, it is clear that Act No. 94 (and particularly the legislative decision to characterize its action as the reinstatement of certain lapsed contractual relationships) is well within the band of constitutional discretion in matters of economic regulation permitted the General Assembly of the Commonwealth of Pennsylvania.

II: AS APPLIED TO EXISTING AND RECENTLY TERMINATED CONTRACTS FOR THE FURNISHING OF SERVICES, THE STATUTORY REMEDY FASHIONED BY PENNSYLVANIA REPRESENTS A RATIONAL AND THEREFORE CONSTITUTIONAL APPLICATION OF MEDIATION AND COOLING-OFF PROCEDURES.

A. The magnitude of the crisis facing the General Assembly was great. On a National level, health expenditures over the period 1950 to 1975 have almost doubled as a percentage of Gross National Product (4.6% to 8.3%) and of personal income (5.7% to 9.9%), with further increases predicted for the future (the Department of Health, Education and Welfare estimates that by 1990, 10% to 12% of Gross National Product will be spent for health care). Hospital expenditures are even higher than overall health expenditures, so that the cost of an average hospital stay is up from $311 in 1965 to $1017 in 1975; over the same period, the average length of hospital stays declined. Executive Office of the President, Council on Wage and Price Stability, Staff Report on "The Problem of Rising

Health Care Costs" at 4, 9, 23, 27 (April 1976) (GPO Stock No. 052-003-00164-1).

The situation in the area of appellant hospitals is even more egregious. While inpatient days have been declining, per diem hospital costs in the Philadelphia area rose from only $29.27 in 1964 to $117.83 in 1974, or 400% in 10 years, with $201.25 per diem projected for 1977 (Ex. nos. 31, 32).

To protect themselves from exposure to this economic risk, and to assure themselves the ability to obtain adequate health care, over half the population of the Commonwealth of Pennsylvania is covered by Blue Cross Plans (A.79 ¶ 6). Appellee Blue Cross of Greater Philadelphia alone has approximately 2,400,000 subscribers (A.78-79 ¶ 5). Thus, literally millions of Pennsylvania residents were subjected to a severe crisis situation by the unanticipated hiatus in their hospitalization coverage which, as noted above, could turn a $90 hospital bill into a $1350 one.

B. The statute. Act No. 94 establishes three time periods in respect of hospitalization contracts between hospital plan corporations and hospitals: a notification period, a hearing period and a negotiation period.

No hospitalization contract may be terminated unless the party seeking the termination gives 90 days advance written notice to the other party to the contract and to the Pennsylvania Insurance Department. If the notice is given 90 days before the scheduled

termination of the hospitalization contract, the contract will terminate in accordance with its terms. If, on the other hand, the dissatisfied party chooses to wait until the scheduled termination date before giving its notice, then the hospitalization contract will in effect be continued by virtue of the statute for the 90 day notification period. 40 Pa.C.S.A. § 6142(c)(2). Therefore as to appellants in No. 75-1698 (who do not allege that any of their contracts would have otherwise terminated prior to October 31, 1975–90 days after the August 2, 1975 effective date of Act No. 94), the mediation and cooling-off period is only the 10 months required for the procedures discussed immediately below.

If a termination involves hospitalization contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the Insurance Department is required to hold public hearings. Pending completion of the Insurance Department's investigation, termination of the hospitalization contracts is suspended for a period not to exceed six months from the end of the notification period described above, and the contract is continued in accordance with its terms. Based on its investigation, the Insurance Department is required to make specific findings as to the facts of the dispute, and to approve termination of the hospitalization contracts or else recommend terms for the continuation of the contracts. Any recommendation of terms by the Insurance Department shall be "in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost." 40 Pa. C.S.A. § 6142(c)(3).

Even if terms are recommended by the Insurance Department, the parties are under no obligation to accept such terms. Rather, the parties are required only to renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms recommended. Pending such negotiations, termination of the hospitalization contracts is suspended for a period not to exceed 90 days from the expiration of the hearing period described above. If negotiations are unsuccessful, the Insurance Department is required to approve termination of the contracts, effective 30 days thereafter. 40 Pa.C.S.A. § 6142(c)(4).[12]

Thus, the legislature has established a carefully detailed and balanced procedure for the orderly termination of contracts greatly affecting the public interest. Notification, public hearings and possible further negotiations are provided for. The terms upon which the

[12] Appellants in No. 75-1691 would have this Court believe that they are ignorant of the purpose of the final 30 day delay (Brief at 18). The purpose, of course, is to afford time to notify all Blue Cross subscribers of the identity of the non-contracting hospitals, so that subscribers thereafter requiring hospitalization may request their physicians to admit them to member hospitals where service benefits will be available, *e.g.* where $90 rather than $1350 will be charged to the subscriber on discharge.

parties ultimately agree are automatically made retroactive to the date of expiration of the contract previously in effect. 40 Pa.C.S.A. § 6142(c)(5). This provision prevents those who require hospitalization during an inter-contract interval from suffering the invidious discrimination of paying $1100 for services for which others pay only $90 both before and after (and where a run-out is applicable, during) the inter-contract interval. Contracts having a minimal impact on the public interest (*i.e.*, hospitalization contracts with hospitals having 5% or less of the beds in the area served by the hospital plan corporation) are subject only to the requirement of 90 days' prior written notification of termination. In no event may a hospitalization contract be extended beyond 10 months (13 months as to appellants in No. 75-1691) from its intended final termination date. And in no event are terms of a new contract forced on the parties.

C. A temporary restoration or continuation of contractual arrangements is constitutionally permissible. As described above, Act No. 94 provides for the restoration or continuation of business relations between contracting parties for a limited period pending private negotiations as a means of alleviating a significant emergency in the public delivery of health care services. Thus, in providing a mechanism to put the Blue Cross system "back to work", Act No. 94 is in the tradition of the Taft-Hartley and Railway Labor Acts.

The constitutional validity of such a statute can be seen from a comparison of the workings and fates of the Taft-Hartley Act of 1947 and the Kansas Industrial Court Act of 1920.

The Federal statute provides for injunctive relief upon application by the Executive after public report by a board of inquiry in cases where a threatened or actual strike or lock-out affects an entire industry or a substantial part thereof engaged in interstate commerce, and if permitted to occur or continue will imperil the national health or safety. The Kansas statute provided for compulsory arbitration of labor disputes, forbade employers from going out of business unless they could show that financial collapse would follow if they continued on the terms fixed, and made strikes and lock-outs unlawful under pain of criminal sanctions.

The constitutionality of the Federal act has been sustained; the Kansas statute has been invalidated. *Steelworkers* v. *United States*, 361 U.S. 39 (1959); *Wolff Packing Co.* v. *Industrial Court*, 262 U.S. 522 (1923).

In assessing the validity of statutory restraints on the freedom of private parties to contract as they will, two factors are crucial. One is the severity of the restriction; it "must not be arbitrary or unreasonable." The other is the need for the curtailment: "exceptional circumstances" may justify otherwise overreaching arrangements. *Wolff, supra*, 262 U.S. at 534.

In terms of the nature of the restraint, it is clear that Act No. 94 presents a *Steelworkers* and not a *Wolff* situation. The Kansas statute sought to force a solution on the parties through compulsory arbitration; Taft-Hartley, on the other hand, provides that contractual arrangements "be resumed or continued for a time while efforts [are] made to settle the dispute." *Steelworkers, supra*, 361 U.S. at 41. Act No. 94, in providing a "cooling off" period during which private negotiations may continue, adopts the less restrictive Taft-Hartley philosophy of limited public encouragement to voluntarism.

In this connection, it should be noted that a relatively recent amendment to the Taft-Hartley Act provides that if a labor dispute affecting a health care institution (defined to include nonprofit hospitals such as appellants) would substantially interrupt the delivery of health care in the locality concerned, a board of inquiry may be established and "[there]after . . . and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time of the impasse in the case of an initial bargaining negotiation, except by agreement, shall be made by the parties to the controversy." 29 U.S.C. § 183(c), as added by Public Law 93-360, 88 Stat. 396.

Nor is it controlling that the Act No. 94 cooling off period is somewhat longer than the periods provided in

the Taft-Hartley Act. The maximum cooling off period under the general provisions, 29 U.S.C. §§ 178-180, is 80 days. In view of the presumably greater resources of hospitals as compared with individual wage earners, and the virtually permanent relationship between Blue Cross and its member hospitals, the 10 month (13 month as to appellants in No. 75-1691) maximum cooling off period selected by the Pennsylvania General Assembly was obviously well within the ambit of legislative discretion.[13]

Apart from the limited severity of the restraint imposed by Act No. 94, the need for public protection is great. As Mr. Chief Justice Hughes stated in *Wolff*, "(t)he extent to which regulation may reasonably go varies with different kinds of business"; "(i)t depends on the nature of the business, on the feature which touches the public, and the abuses reasonably to be feared." 262 U.S. at 539. Thus, the "small extent of the injury" to the public that might result from a discontinuation of Wolff's packing plant did not

[13] Appellants attack the reliance of the District Court on the cooling-off line of cases, arguing that striking railroad workers could seek other employment but hospitals here are "compelled" to provide service to Blue Cross patients. It is open to question whether Act No. 94 provides any more than that *if* the hospital chooses to admit a Blue Cross subscriber *then* payment shall be subject to the terms of the statute (some member hospitals routinely turn away Blue Cross subscribers, *e.g.*, when they seek admission for premature termination of pregnancy procedures), thus giving the hospital the same theoretical freedom as the striking railroad worker. In practice the railroad worker and the hospital are both effectively tied to their respective callings, and the analogy drawn by the District Court is sound.

justify the "drastic regulation" sought to be imposed by Kansas. *Id.* at 543, 544. The public injury resulting from a discontinuation of subscribers' coverage, on the other hand, is direct, immediate, widespread and intense.[14]

Nor does it matter that steelworkers and railway employees today contract against the background of statutory contract continuation periods. Prior to the Railway Labor Act of 1926, in sustaining the constitutionality of the Adamson Law of 1916, this Court held that the legislative power "extend(s) to doing that which was essential to prevent operation [of the railroads] from being completely stopped by filling the interregnum created by an absence of a conventional standard of wages because of a dispute on that subject between the employers and employees by a legislative standard binding on employers and employees for such a time as might be deemed by the legislature reasonably adequate to enable normal conditions to come about as the result of agreements as to wages between

[14] Like *Wolff*, the *Fornaris* case cited by appellants is clearly distinguishable from Act No. 94 in terms of the severity of the restriction and the need for the curtailment. The Puerto Rico statute in *Fornaris* provided that dealership contracts with Puerto Rico dealers could *never* be terminated in accordance with their terms in the absence of a substantial failure of performance by the dealer. Act No. 94, on the other hand, imposes only a 10 month (13 month) restraint and provides an unlimited right of recoupment. Nor does the economic protection of hardware dealers compare to the protection of the public health. *Fornaris* v. *Ridge Tool Co.*, 423 F.2d 563 (1st Cir. 1970), *rev'd on other grounds*, 400 U.S. 41 (1970).

the parties." *Wilson* v. *New*, 243 U.S. 332, 351 (1917). The preexisting relationships there had been originally established prior to the enunciation of the doctrine of *Wilson* v. *New* (just as the Blue Cross-hospital relationship here had been established prior to the enactment of Act No. 94), thereby clearly demonstrating that the adoption of the ruling principle need not antedate the relationship affected. In any event, *Wilson* v. *New* was established law prior to the development of the Blue Cross concept in Pennsylvania in the 1930's.

D. Requiring Insurance Department approval of terminations is constitutionally permissible. If statutory extension of a contract for a cooling off period of up to 10 months (13 months) is constitutionally permissible, it is similarly allowable to condition termination of the contract during that period on the approval of the Pennsylvania Insurance Department.

The Natural Gas Act is typical of regulatory statutes in providing that companies may abandon jurisdictional facilities only with the prior permission of the administrative agency. 15 U.S.C. §717f(b). Under this provision, it is clear that the legislature may require performance of a contract pending administrative approval of termination notwithstanding the termination of the contract in accordance with its terms. *United Gas Pipe Line* v. *Federal Power Commission*, 385 U.S. 83 (1966).

United involved a contract for the sale of certain gas (the "Johnson Bayou gas") to run for 10 years and from year to year thereafter unless terminated by either party on 90 days' notice. Prior to the scheduled termination date of the primary term of the contract, the seller ("Continental") gave notice of its election to terminate. After fruitless negotiations for a new contract, the seller filed for and obtained a rate increase, effective as of the scheduled termination date of the primary term. The purchaser ("United"), after advance notice to the seller, ceased buying from the seller on the scheduled termination date. Upon petition by the seller, the regulatory commission held that the purchaser had abandoned facilities and services without obtaining its prior approval, in violation of the statute. Accordingly, the commission ordered the purchaser to resume its purchases from the seller at the new higher rate and in volumes consistent with the terms of the lapsed contract.

On appeal, this Court unanimously upheld the commission. After finding that the statute applied to the facts at hand, the Court reached the constitutional issue:

> "United claims that it does not need the Johnson Bayou gas to serve its customers and that the forced purchase of gas at prices set by Continental and approved by the Commission without regard to the prices at which United under contract or competition is bound to sell the gas deprives it of property without due process of law. In our view, these claims are premature. We do not hold that it would be inappropriate for the Commission to permit abandonment in this case if it is asked to do so and the necessary findings are made. We hold only that United has abandoned facilities and service without the consent of the Commission and that it must reactivate those facilities and restore the service until and unless the statutory consent is obtained." 385 U.S. at 91.

Similarly, in the case of Act No. 94, there is no constitutional infirmity in a statute conditioning termination of lapsed contracts on the obtaining of administrative approval.

Indeed, administrative approval of contract terminations is if anything more appropriate in the case of Act No. 94 than in *United*. *United* continued a contract altered to benefit one party; Act No. 94 simply leaves the parties where it finds them. In *United* it was past history and therefor clear which party was to be benefited; it is impossible to predict whether the hospital plan corporation or the hospitals will be advantaged by continuation of some future contract. In *United* all its future interstate gas purchases would presumably be subject to regulation and recoupment would be piecemeal at best; under Act No. 94, an unlimited recoupment right exists. And the statute in *United* permitted indefinite continuation of contracts, whereas Act No. 94 has a 10 month (13 month) limit.

It may be, of course, that a particular refusal to permit termination in some future dispute would constitute an abuse of administrative discretion, rendering Act No. 94 unconstitutional as there applied. But surely it would be, as this Court stated in *United*, "premature," at the outset of Pennsylvania's experiment to hold Act No. 94 unconstitutional on its face.

III: THE STATUTORY REMEDY FASHIONED BY PENNSYLVANIA CONTEMPLATES AN UNLIMITED RIGHT OF RECOUPMENT AND IS THEREFORE FREE OF CONSTITUTIONAL INFIRMITY

A. Pennsylvania has the power to regulate hospital charges. The constitutional standard for public regulation of the charges and other aspects of private enterprise derives from the common law concept of business affected with a public interest.

This concept was first generally enunciated in the United States through the decision of this Court in *Munn* v. *Illinois*, 94 U.S. 113 (1877). Upholding the authority of the Illinois legislature to fix the maximum rates charged by a specified class of grain warehouses, Mr. Chief Justice Waite was led

> "to inquire as to the principles upon which this power of regulation rests, in order that we may determine what is within and what is without its operative effect. Looking, then, to the common law, from whence came the right which the Constitution protects, we find that when private property

> is 'affected with a public interest, it ceases to be *juris privati* only.' This was said by Lord Chief Justice Hale more than two hundred years ago, in his treatise *De Portibus Maris*, 1 Harg. Law Tracts 78, and has been accepted without objection as an essential element in the law of property ever since. Property does become clothed with a public interest when used in a manner to make it of public consequence, and affect the community at large . . .
>
> "*It matters not in this case that these plaintiffs in error had built their warehouses and established their business before the regulations complained of were adopted.* What they did was from the beginning subject to the power of the body politic to require them to conform to such regulations as might be established by the proper authorities for the common good." 94 U.S. at 125-26, 133 (emphasis supplied).

Following *Munn*, the courts struggled with the public interest standard, upholding certain State laws and, especially during the heyday of substantive due process, invalidating others. The uncertainties in the *Munn* test were finally put to rest with this Court's announcement of the modern conception of the scope of the police power in *Nebbia* v. *New York*, 291 U.S. 502 (1934). Since *Nebbia*, few State economic statutes have been held by this Court to be beyond the power of the legislature to enact.

Nebbia upheld the authority of the New York legislature to fix the rates charged by stores for certain

retail sales of milk. Rejecting the assertion that regulation is only permissible in respect of public utilities, monopolies or businesses holding public franchises, this Court in *Nebbia* explained the true basis of its holding in *Munn*:

> "It is true that the court [therein] cited a statement from Lord Hale's *De Portibus Maris*, to the effect that when private property is 'affected with a public interest, it ceases to be *juris privati* only'; but the court proceeded at once to define what it understood by the expression, saying: 'Property does become clothed with a public interest when used in a manner to make it of public consequence, and affect the community at large' (p. 126). Thus understood, 'affected with a public interest' is the equivalent of 'subject to the exercise of the police power'; and it is plain that nothing more was intended by the expression . . .
>
> "It is clear that there is no closed class or category of businesses affected with a public interest, and the function of courts in the application of the Fifth and Fourteenth Amendments is to determine in each case whether circumstances vindicate the challenged regulation as a reasonable exertion of governmental authority or condemn it as arbitrary or discriminatory. *Wolff Packing Co.* v. *Industrial Court*, 262 U.S. 522, 535. The phrase 'affected with a public interest' can, in the nature of things, mean no more than that an industry, for adequate reason, is subject to control for the public good.

> "Price control, like any other form of regulation is unconstitutional only if arbitrary, discriminatory, or demonstrably irrelevant to the policy the legislature is free to adopt." 291 U.S. at 532-33, 536, 539.

Thus, State regulation of hospital rates is valid if "a reasonable exertion of governmental authority." And if grain elevators *(Munn)*, milk sales *(Nebbia)*, and gas producers (*Phillips Petroleum Corp.* v. *Wisconsin*, 347 U.S. 672 (1954)), are subject to economic regulation, it cannot be gainsaid that hospitals are sufficiently "affected with a public interest" also to be amenable to such controls. Indeed, as indicated in Part 1 of Annex A, hospitalization has been regarded as a "public service" under Pennsylvania law since the beginning.

B. Pennsylvania may implement its regulatory scheme by incorporating by reference a filed rate formula. The effect of Act No. 94 is to impose a maximum 10 month (13 month) rate regulatory scheme on hospitals. Appellants would have this Court hold that the only option constitutionally open to the Commonwealth of Pennsylvania was the creation of a full-blown hospital regulatory commission. Rather than undergo the delay and expense of such an endeavor, the General Assembly chose to adopt by reference the regulatory formulae contained in contracts, some lapsed, filed with and approved by the Pennsylvania Insurance Department.

It is clear that the legislature could have directly enacted the ratemaking formulae. Indeed, this is precisely how the Illinois legislature fixed the formula in *Munn*, and this Court therein noted that "(i)n countries where the common law prevails [this] has been customary from time immemorial." 94 U.S. at 133. Alternatively, the legislature could have incorporated by reference a ratemaking formula fixed by administrative agency regulation. Such was the approach of the New York legislature in *Nebbia*. Finally, authority may be given an administrative agency to require that the company subject to rate regulation file a schedule of rates, with the agency having the power to approve or reject such rates. See, e.g., *Pennsylvania Water and Power Co.* v. *Federal Power Commission*, 343 U.S. 414, 416-17 (1952).

Nor is it unusual to find a ratemaking scheme based on administrative approval or disapproval of rates filed by the regulated company. Indeed, many States, in addition to Pennsylvania, have adopted precisely this approach for Blue Cross ratemaking purposes. See, *e.g.*, Part 2 of Annex A. See also Part 3 of Annex A (Federal regulation).

Thus, there is no invalidity in a formula's being contained in a private contract where an administrative agency of the State, exercising its quasi-legislative authority to set rates, has passed on and approved the formula in a prior filing with the agency.

C. The right of unlimited post-cooling off recoupment afforded by Act No. 94 eliminates the issue of confiscation. It is a commonplace that when costs are rising a regulated industry complains about "regulatory lag," *i.e.*, the delayed price relief caused by the wait for the outcome of the price-setting process.[15] But the process works both ways, of course, and when costs are falling the consumer may be injured by delays in fixing lower rates or prices.

In *Prendergast* v. *New York Tel. Co.*, 262 U.S. 43 (1923), relied upon by the dissenting judge below, this Court overturned an effort by New York to fix lower temporary rates prior to the completion of the normal regulatory process. The Court noted that a bond for refund would protect the customer, but that New York had afforded no comparable protection for the telephone company if the temporary rates proved to be lower than the final rates. 262 U.S. at 51. *Prendergast* triggered the development of the concept of "recoupment," *i.e.*, the right of the regulated entity to make up any shortfall caused by temporary rates,

[15] It has long been assumed that where regulatory lag delays a rate *increase* for a reasonable period of time, no confiscation issue of constitutional dimension is raised since the delay is merely incident to the process of regulation. See, e.g., *New Rochelle Water Co.* v. *Public Service Comm'n*, 31 N.Y.2d 397, 292 N.E.2d 767 (1972) (10 month delay constitutional); *Hope Natural Gas Co.* v. *Federal Power Comm'n*, 196 F.2d 803, *rehearing denied*, 197 F.2d 522 (4th Cir. 1952) (5 month delay constitutional). However, because appellants in No. 75-1691 assert that Act No. 94 *reduced* their rates, the following recoupment discussion is relevant. *New Rochelle Water Co., supra*, 292 N.E. 2d at 773.

not by retroactively repricing services previously furnished (as appellants here seem to think), but by prospectively raising the price of currently-furnished services to recoup any deficiency in revenue.

The recoupment principle was sustained in *Bronx Gas & Elec. Co.* v. *Maltbie*, 271 N.Y. 364, 3 N.E. 2d 512 (1936). Its constitutionality was argued before this Court in *Driscoll* v. *Edison Light & Power Co.*, 307 U.S. 104 (1939), but only Justices Frankfurter and Black reached the issue and sustained the principle, the majority of the Court preferring to decide the case on the substantive due process grounds then still in vogue with respect to economic matters. Finally in *Beaver Valley Water Co.* v. *Driscoll*, 28 F. Supp. 722 (W.D. Pa. 1939), a three-judge district court squarely upheld the constitutionality of the recoupment alternative.

With the eclipse of this Court's substantive due process involvement in economic regulation, see, *e.g.*, *Day-Brite Lighting, Inc.* v. *Missouri*, 342 U.S. 421, 424-25 (1952), the issue appears never to have returned to this Court, but its application is obvious. A regulatory agency may, without making a formal adjudication on the confiscation question, permit rates to be increased, if the rights of the consumer are protected by a refund obligation. Correspondingly, as here, the regulatory authority may, without becoming entangled in the thicket of the confiscation question, require rates to be decreased, if there is a clear right to recover any lost revenue.

Here the amount in dispute is approximately 3% of the base charge,[16] the regulated industry is well situated to administer any required price increases (indeed, appellants confess that the hospitals are able to maintain the unregulated portion of their charges at levels as much as 40% above the regulated levels. Brief in No. 75-1691 at 7, Brief in No. 75-1698 at 3, 9), and the statute provides an unrestricted opportunity to charge as much as the traffic will bear after the expiration of the 10 month (13 month) cooling-off period (assuming no retroactive contract has been voluntarily agreed to in the interim). Under the circumstances, appellants confiscation arguments are too remote and speculative to justify reversal of the District Court's judgment.

IV: THE COST-OF-SERVICE RATE FORMULA CONTAINED IN THE BLUE CROSS-DVHC CONTRACT DOES NOT RESULT IN HOSPITAL RATES FOR BLUE CROSS SUBSCRIBERS WHICH FALL BELOW THE CONSTITUTIONAL ZONE OF REASONABLENESS

A. Structure and purpose of the Blue Cross-DVHC contract. The July 1, 1971 contract between Blue Cross and DVHC incorporated by reference by Act

[16] The prior Blue Cross-DVHC contract provided no "plus factors." The latest position of the parties is that a settlement can be effected between Blue Cross and DVHC if a 3% "plus factor" is added to the reimbursement to cover the aggregate of the omitted items disputed herein.

No. 94 appears as Exhibit no. 17 (Ex. 147a-262a), and prior to the enactment of the Act was amended as of July 1, 1972 (Ex. no. 18, Ex. 263a-265a) and was amended and extended by the so-called "Summary of Principles" (Ex. no. 20, Ex. 269a-285a) and the settlement in *Crozer-Chester* v. *Blue Cross of Greater Philadelphia* (Ex. no. 23, Ex. 286a-289a).

The Blue Cross-DVHC contract is a formidable document, representing the culmination of more than three decades of joint effort among the Pennsylvania Insurance Department, the hospitals and Blue Cross to hone the techniques for purchase of hospitalization service to a fine edge. In addition to covering routine business matters, the contract is a regulatory tool of major significance, *e.g.:* unnecessary hospitalization is monitored and discouraged (§§ 2.3, 11) (Ex. 152a, 162a-164a); duplication of laboratory tests is discouraged (§ 7) (Ex. 157a-158a); fees for professional services are limited to "reasonable and customary" charges and a report of fees of anesthesiologists, pathologists and radiologists must be made to the trustees of the hospital (§§ 10.1.2, 10.2) (Ex. 160a, 162a); cost saving programs, systems analysis and use of modern management techniques are encouraged (§§ 12-14) (Ex. 164a-166a); the dispensing of drugs by generic name is required (§ 16) (Ex. 166a-167a); the "prudent buyer concept" of purchasing is required (§ 19) (Ex. 173a-174a); a detailed safety program is imposed (§ 20 and Exhibit C) (Ex. 174a, 260a-262a); the hospital is required to maintain accredited status

(§ 23) (Ex. 176a); capital projects in excess of $100,000 and expansion of certain "big ticket" services such as open-heart surgery and hemodialysis are made subject to prior approval of an independent health planning agency (§ 24) (Ex. 177a-181a, 271a-272a); and costs, facilities and services information is to be made open to the public (§ 28) (Ex. 183a). Disputes arising under the contract may be appealed to a court, where they are heard *de novo* (§ 21) (Ex. 174a-176a, 271a).

Of course, it is in the area of regulating the rates to be charged for services to Blue Cross subscribers that the contract most clearly manifests its regulatory character. The hospitals are required to submit detailed budgets under a prescribed uniform accounting format at least 45 days prior to the fiscal year; the budget undergoes a detailed professional review by the Blue Cross staff and, unless appealed, the Blue Cross decision on an interim rate is final (§ 18 and Budget Forms A through K) (Ex. 168a-170a, 222a-259a). The *Crozer-Chester* litigation was an example of the hospitals' exercise of their right to have court review of the Blue Cross-fixed interim reimbursement rates (see Ex. no. 23) (Ex. 287a-289a) (*see also* generally A.91-92 ¶ 48). As of the end of each fiscal quarter, the hospital submits actual cost reports to Blue Cross. Based on this experience the interim rate may be adjusted, both retroactively and prospectively. Following the end of a fiscal year, final settlement is made

based on actual cost as verified by independent certified public accountants and subscriber usage for the period (§ 2.4.5 of Exhibit A) (Ex. 218a-219a) with, of course, a right to appeal for *de novo* review in the courts (*see also* A.92 §§ 50, 52).

The basis of payment to the hospitals is set out in Exhibit A to the contract (Ex. 185a-220a).[17] Essentially the basis of payment is derived from certain "principles" promulgated under Medicare[18] on July 1, 1967, and therefore all "current and future" Medicare interpretations, instructions and manuals relating to determinations of cost are expressly made applicable, except where the specific text of Exhibit A to the Blue Cross-DVHC contract would make such material inappropriate (Ex. 185a).

Since a typical hospital will have four classes of patients, *i.e.*, Medicare, Medicaid, Blue Cross and so-called "self-pay," a fundamental requirement of the formula is that "reasonable costs associated with Subscriber Covered Services will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by Blue Cross." Principle 2.1.1(a) (Ex. 207a). *Cf.* 20 C.F.R.

[17] The "prospective rate base" method (§ 18.5 of the contract and Part II of Exhibit A thereto) (Ex. 172a-173a, 220a-221a) is an alternative incentive method of payment which permits Blue Cross and a hospital to fix a firm rate prospectively, so that any savings thereafter resulting inure to the benefit of the hospital. None of the DVHC hospitals had elected this option at the time Act No. 94 was enacted.

[18] See generally 42 U.S.C. § 1395x(v) and 20 C.F.R. §§ 405.401-405.488.

§ 405.402(a). The contract expressly declares that "payments to the [hospital] . . . should be fair and equitable to both the [hospital] . . . and Blue Cross." Principle 2.1.2(a) (Ex. 208a).

This general approach is then refined by a number of specific provisions. Depreciation is allowable not only upon purchased assets, but also upon assets furnished by private donations or by Hill-Burton or other Federal or public funds. Principle 1.1 (Ex. 186a-189a). *Cf.* 20 C.F.R. §§ 405.415-405.418. Interest expense on both current and capital indebtedness is allowable (the DVHC form of contract is drafted specifically for nonprofit institutions and therefore has no occasion to provide for return on equity capital[19]) Principle 1.2 (Ex. 189a-191a). *Cf.* 20 C.F.R. § 405.419.

Bad debts (except with respect to certain deductibles and co-insurance amounts), charity and courtesy allowances are treated as deductions from revenue and are not included in allowable costs. Principle 1.3 (Ex. 191a-194a). *Cf.* 20 C.F.R. § 405.420. However, offsetting this is the principle that unrestricted grants, gifts, and income from endowments should not be deducted from operating expenses in computing reimbursable costs. Principle 1.6 (Ex. 200a-201a). *Cf.* 20 C.F.R. § 405.423.

Identifiable costs incurred directly or indirectly for research purposes which exceed normal costs of usual

[19] Therefore appellants' reliance on *Denver Union Stock Yard Co.* v. *United States*, 304 U.S. 470 (1938), and similar "reasonable rate of return" cases is wholly inapposite.

patient care and are not otherwise reimbursed are excluded from allowable cost. Principle 1.5 (Ex. 199a-200a). *Cf.* 20 C.F.R. § 405.422. But the net cost of approved educational activities is an allowable cost. Principle 1.4 (Ex. 194a-199a). *Cf.* 20 C.F.R. § 405.421.

B. The real purpose of the appellants in attacking the rate formula is to eviscerate Pennsylvania's hospital regulatory program. The appellants complain of the relatively low Blue Cross indemnity benefit and urge that Pennsylvania should require full "charges" reimbursement (Brief in No. 75-1698 at 4). If that were so there would, of course, be no reason for any hospital to contract with Blue Cross and the whole indirect method of hospital regulation in Pennsylvania would collapse. Each hospital could charge what it liked, buy as many "big ticket" units as it desired, use only the most expensive brand name drugs, and so forth. The President of Blue Cross testified that in his view the real basis for the hospitals' complaint was that the cost control features of the 1971 Blue Cross-DVHC contract were having their intended "bite", *e.g.*, on disallowance of depreciation for unneeded facilities, refusal to reimburse medically inappropriate hospitalization and failure to use generic drugs and to conform to the prudent buyer concept (A.133 ¶ 89).[20]

[20] It should be noted that many of the contract requirements in effect mandate hospital-wide practices (*e.g.*, safety, accreditation, purchasing, generic drug use) and thus indirectly but quite effectively benefit the "self-pay" patient population.

Appellants in No. 75-1698 are candid enough to confirm that their aim is to eviscerate the cost control efforts of Medicare, Medicaid and Blue Cross, which refuse to pay for, *inter alia*, "misutilized patient days" (J.S. 16).

C. Appellants lack standing to raise an issue of confiscation. The law of confiscation as it has developed in this Court is a manifestation of the concern of the Court with the indirect taking of the private property interests of the owners of a business through overly stringent price regulation. Under the law of Pennsylvania, however, the appellants who are directors and officers of the appellant hospitals have, as such, no individual interest in the property of the hospitals. 15 Pa.C.S.A. § 7553. The appellant hospitals as corporations constitute, of course, only their individual members clothed with the immunity of limited liability. Under Pennsylvania law the members of a nonprofit hospital corporation have no interest in the assets of the hospital during its operation (15 Pa.C.S.A. § 7553). The assets of the hospitals are clearly committed to "charitable purposes" as that term is used in the applicable statute (15 Pa.C.S.A. § 7103), and at dissolution the assets are not distributable to the members but rather are subject to redeployment at the hands of the Commonwealth under a statutory codification of the *cy pres* principle. 15 Pa.C.S.A. §§ 7549(b), 7967(c). Therefore, to the extent that Act No. 94

represents a legislative decision that a part of the assets of these nonprofit charitable hospitals shall be utilized for the support of medical care for indigents (and other disputed matters), it represents an exercise of conventional State regulation of private charity which implicates no Federal claim under the Due Process Clause based on a taking theory.[21] Cf. *Simon* v. *Eastern Kentucky Welfare Rights Org.*, 48 L. Ed. 2d 450, 461 (1976) ("The necessity that the plaintiff who seeks to invoke judicial power stand to profit in some personal interest remains an Art III requirement").

D. Confiscation exists for constitutional purposes only where the end result of the rate formula is below the zone of reasonableness. The decision in *Smyth* v. *Ames*, 169 U.S. 466 (1898), laid down the rule of a fair return on a fair value as the test of a ratemaking

[21] Under a modern development, some of the hospitals may have no members. 15 Pa.C.S.A. § 7316(a)(7). At one time the charitable corporation, viewed as a juridical entity, had rights as against the State which created it. *Dartmouth College* v. *Woodward*, 4 Wheat. 518 (1819). But Pennsylvania, like the other States, has by appropriate constitutional and statutory provisions reestablished its unrestricted right to modify or abolish its corporate creations. Constitution, Art. X, §§ 1-3; 15 P.S. § 3, 15 P.S. § 4 note, 15 Pa.C.S.A. § 106. The record shows that with the possible exception of Pennsylvania Hospital (discussed separately in Part 1 of Annex A) which is in any event a corporation having members, all incorporated hospitals in Pennsylvania are fully subject to the legislative power of the Commonwealth (A.93-94 ¶ 56). *See generally* "Foreword" to *Purdon's Pennsylvania Statutes Annotated*, Titles 13-15, at 63-64.

formula. Following *Smyth* v. *Ames*, the courts determined questions of fair value of rate base and fair rate of return thereon. See, e.g., *Prendergast*, *supra*. Finally the rule of *Smyth v. Ames*, with its emphasis on close judicial supervision of ratemaking, was abandoned.

This Court has now indicated that the Constitution is concerned with the results of rates fixed rather than with the method used in arriving at them. Under the rule of *Hope Natural Gas Co. v. Federal Power Commission*, 320 U.S. 591 (1944), ratemaking methods are left to legislatures and administrative agencies exercising their quasi-legislative ratemaking function, with the role of the courts being confined only to determining whether the rates established are actually confiscatory in operation.

In *Hope Natural Gas*, this Court upheld a rate order issued by the Federal Power Commission as just and reasonable for purposes of the Natural Gas Act.[22] "It is not theory but the impact of the rate order which counts," this Court stated. "If the total effect of the rate order cannot be said to be unjust and reasonable, judicial inquiry . . . is at an end." 320 U.S. at 602. Applying its end result test to the order reducing Hope's rates, the Court held that "Rates which enable

[22] Although *Hope Natural Gas* turned on the construction of a Federal statute, the test therein announced coincides with the constitutional standard. *Federal Power Commission* v. *Natural Gas Pipeline Co.*, 315 U.S. 575, 586 (1942); *Permian Basin Area Rate Cases*, *supra*, 390 U.S. at 770, 780-81 (upholding a 22 month "moratorium" on rate increases).

the company to operate successfully, to maintain its financial integrity, to attract capital, and to compensate its investors for the risks assumed certainly cannot be condemned as invalid." *Id.* at 605.

E. The Medicare-based rate formula reimburses the hospitals for the full costs of serving Blue Cross subscribers, and no more is required by the Constitution. Appellants' confiscation claims are not a model of precision. At no point in this litigation have they identified specifically that language in Exhibit A to the Blue Cross-DVHC contract which they consider constiutionally offensive. However, they variously complain of failure to reimburse for care to indigent patients, bad debts (including particularly patients who enter a hospital as Blue Cross subscribers and exhaust their coverage before their treatment is complete), research and "operating growth needs."

At least since *Lindheimer* v. *Illinois Tel. Co.*, 292 U.S. 151 (1934), it has been clear that regulated rates need not include "provisions for capital additions, over and above the amounts required for capital consumption." 292 U.S. at 174. Similarly, denial of an allowance for research represents an application of this principal to accumulations for the acquisition of intangible assets in the form of expanded knowledge, and the costs of which in any event should be matched to the excluded gift, grant and endowment income.

Bad debts arising from Blue Cross subscribers exhausting their coverage must necessarily be excluded,

or there would be a rule of constitutional dimension that a third-party payor could never limit the amount of coverage. Obviously, if Blue Cross must reimburse the hospital for services beyond the exhaustion date, that date is meaningless. In any event, on September 13, 1976 Pennsylvania amended its Medicaid regulations, 6 Pa. B. 3050, to provide that when "the period covered by a Blue Cross contract . . . ends, the patient is eligible for full [Medicaid] . . . benefits."

The principal issue is the allocation of cost of indigent care. The rate formula matches costs and revenues by excluding both the cost of service to indigents and gift, grant and endowment income, which has been a traditional source of funding for medical services to the poor. Appellants, however, seek to have this Court ordain that the only method of supporting hospitalization for indigents open to Pennsylvania is by surcharge on the Blue Cross rates. As appellants in No. 75-1698 readily concede, the locus of the burden of medical care for indigents is a policy question. Brief at 5, 11, 22. As such, at least since *Hope Natural Gas*, it has in this Court not been viewed as a justiciable question. Two Blue Cross subscribers, one earning $100,000 and the other $10,000 per year, may be asked to bear a total of $20 as their share of indigent medical care. Imbedding that cost in the Blue Cross rate structure will allocate the burden on a per capita basis. But Pennsylvania is surely free under the Due Process Clause to elect direct Medicaid payments to the hos-

pitals and to utilize its 2% State income tax as the allocation means, resulting in a spreading of the cost according to ability to pay (*i.e.*, $18.18 to $1.82, rather than $10 to both).

As noted above, appellants in No. 75-1698 point out no fewer than three times that inclusion of the disputed items in the Act No. 94 reimbursement formula is a matter of policy (Brief at 5, 11, 22). As they also concede, the Pennsylvania General Assembly has been responding to the hospitals' complaints that the existing Medicaid formula is unsatisfactory (Brief at 10).[23]

The policy nature of this precise point has been reached in *dictum* by the New York Court of Appeals:

> "Theoretically, it could be argued, and legally sustained, that the voluntary [*i.e.*, non-profit] hospitals are entitled to reimbursement limited to the allocated cost of providing services for [Blue Cross] subscribers. Instead, by [New York] statute and regulation the [Blue Cross] subscribers through the reimbursement scheme are required also to contribute to non-income producing services required of the voluntary hospitals from which the paying subscribers may and usually receive no benefit...
>
> "The nub of the vexing problem is that hospital costs have been spiraling out of reach of an economically tolerable rate-structure for [Blue Cross], that is, the rate-structure under which it charges premiums to subscribers. Some of these costs have nothing to do with the costs directly allocable to the services rendered to the subscriber.
>
> "*Neither [Blue Cross] nor the subscribers owe a duty morally or legally, except for the statute now applied, to support the hospitals, but only to pay an allocable share of that support, not less than the cost of the services received by the subscribers, who are paying patients.*" *Presbyterian Hospital* v. *Ingraham*, 39 N.Y.2d 867, 386 N.Y.S.2d 217 (1976) (emphasis supplied).[24]

[23] *See* act of July 15, 1976 (No. 202), amending act of June 13, 1967 (P.L. 31), § 443.1 (62 P.S. § 433.1), by eliminating a 60-day benefit period limitation.

In this connection, the Massachusetts courts have held that, although indigent care *may* be included in the Blue Cross reimbursement formula, there is no requirement that such formula *must* include disputed

[24] While unnecessary to a decision at this point, appellees pointed out below that the hospitals could not surmount the overall loss test of *Wilcox* v. *Consolidated Gas Co.*, 212 U.S. 19, 54 (1909). For confiscation purposes it is necessary to add back "depreciation" expense claimed on contributed property. *Lindheimer*, *supra*, 292 U.S. at 167 (depreciation expenses for ratemaking purposes need only provide an allowance "to maintain the integrity of the investment"). See also *United States* v. *Chicago B. & Q.R. Co.*, 412 U.S. 401 (1973) (denying depreciation deductions for Federal income tax purposes in respect of facilities paid for from public funds); *Detroit Edison Co.* v. *Comm'r*, 319 U.S. 78 (1943) (denying depreciation deductions for Federal income tax purposes in respect of facilities paid for by customers). "Depreciation reflects the cost of an existing capital asset, not the cost of a potential replacement," and the cost to appellant hospitals of contributed property is zero. *Chicago, B. & Q.R. Co. supra*, 412 U.S. at 415. The record shows that without such "depreciation deductions", the appellants very likely would show an overall profit (A135-36 ¶ 3).

items. Compare *Massachusetts Hosp. Serv., Inc.* v. *Commissioner of Admin.*, 218 N.E. 2d 383 (Mass. 1966), with *Murphy Nursing Home* v. *Rate Setting Commission*, 305 N.E. 2d 837, 842 (Mass. 1973).

Moreover, it should be noted that all but one of the appellant hospitals accepts Hill-Burton funds from the Federal government (A.131 ¶ 84), thereby obligating themselves to provide "a reasonable volume" of free care to indigents. 42 U.S.C. § 291c(i)(2). See *Corum* v. *Beth Israel Medical Center*, 359 F. Supp. 909, 917 (S.D.N.Y. 1973) ("a recipient of Hill Burton funds is required by the statute to provide such services in such portion or portions of its facility as will constitute a reasonable volume in light of the needs of the community and the amount of the grant").

The District Court in the instant case found that the omissions from the rate formula adopted by Pennsylvania were permissible. Similarly, the omissions from the Massachusetts formula were sustained by this Court. *Murphy Nursing Home, supra*, 305 N.E. 2d 837 (Mass. 1973) (no issue of confiscation arises where provider is not legally obligated to receive and care for nonincluded indigent patients), *appeal dismissed for want of a substantial federal question*, 417 U.S. 962 (1974). As the District Court noted, except for voluntarily incurred Hill-Burton obligations, there is no legal requirement that hospitals in Pennsylvania render indigent care. 409 F. Supp. at 826. Thus, appellants would impose on Blue Cross subscribers a

constitutional duty to contribute to a charity of appellants' choosing, *i.e.*, to underwrite the cost of charitable endeavors voluntarily engaged in by "charitable" hospitals.[25]

Other disputed omissions from the Pennsylvania formula are similar. For example, to read into the Constitution a requirement that hospitals be reimbursed for free care provided to highly compensated doctors and their families is, to say the least, novel.

To be sure, reasonable men may differ as to whether or not indigent care and other disputed items should be factored into the rate formula as a matter of public policy.[26] But a legislative decision against such inclusion, certainly as applied to non-profit hospitals (whose charitable endowment is not a credit in the rate formula, who have tax-exempt dollars in their institutional

[25] Appellants in No. 75-1691 take the District Court to task (J.S. 19-20) for allegedly failing to perceive the charitable nature of the appellants, all of which are nonprofit charitable institutions. But it is precisely because appellants are committed to charity that they cannot, certainly as a constitutional matter, force the Blue Cross subscriber to pay for the costs of the work which the hospitals hold out as a charity. Appellants' view of "charity" smacks of a private tax levied upon those fortunate enough to enjoy Blue Cross benefits.

[26] Appellants in No. 75-1691 point out that the 1970 "Accreditation Manual for Hospitals" published by the Joint Commission on Accreditation of Hospitals, views indigent care as a laudable goal (Brief at 29-30). As appellees have pointed out, however, the "Principles of Payment for Hospital Care" published by the American Hospital Association at the inception of the Medicare program, expressly stated that reimbursement for such expenses was unquestionably improper (A.120 ¶¶ 60, 61).

pockets, who have recently benefited from an increase in welfare payments, and who stand to benefit further from future increases in welfare payments), is rational and therefore permissible. "So long as its judgments are rational, and not invidious, the legislature's efforts to tackle the problems of the poor and the needy are not subject to a constitutional straightjacket." *Mathews* v. *de Castro*, 45 U.S.L.W. 4049, 4050 (December 13, 1976), quoting *Jefferson* v. *Hackney*, 406 U.S. 535, 546-47 (1972).

And applying the end result test to the instant case, it is also clear that there has been no confiscation. The last approved reimbursement formula is cost-based, and operates to pick up periodically all proper inflationary cost increases.[27]

[27] The dissenting judge below was evidently confused by the various "hold-down" provisions of the Blue Cross-DVHC contract. Rates for the 1971-72 year could not exceed approximately 112% of the previous year's rates, but a hospital which exceeded its cost ceiling was permitted to cancel the contract on 15 days' notice (§ 18.4) (Ex. 171a-172a). *See also* Principle 1.4.7 (Ex. 198a-199a) and A.86 ¶ 29. The contract contemplated negotiation of a 1972-73 "hold-down", but the July 1, 1972 amendment recognized that controls under the Economic Stabilization Act had superseded most of the restrictions under the contract (Ex. no. 18) (Ex. 263a-265a). For 1972-73, intern and resident costs could not exceed 107% of the previous year's costs. Principle 1.4.7 (Ex. 198a-199a). The *Crozer-Chester* settlement recognized that by August 1974 all of these "hold-downs" had expired, and confirmed that "full reasonable costs" would be paid by Blue Cross (Ex. no. 23) (Ex. 288a ¶ 4). As indicated earlier, Blue Cross has the duty of fixing "interim" rates, and a misunderstanding arose when Blue Cross proceeded to exercise this power following the enactment of

(footnote continued on next page)

V: THE DISTRICT COURT WAS CORRECT IN CONCLUDING THAT THE ISSUE OF ALLEGED CONFISCATION COULD BE RESOLVED BY AN EXAMINATION OF THE COST-OF-SERVICE RATE FORMULA ITSELF, WITHOUT THE NEED FOR A TRIAL.

Appellants now assert that, even if their motion below for summary judgment was properly denied, nevertheless it was improper to have granted appellees' motion below for summary judgment. At a minimum, they now allege, the lower court should have required a trial of disputed issues of fact.

There is no occasion for remand of the instant case. No facts are in dispute. The only dispute revolves around the legal effect (*i.e.*, the constitutionality) of a rate formula that does not include reimbursement to hospitals for free care and other desired elements, of the establishment of a "stand by" mechanism for future contract disputes, and of the impact on these issues of the existence of an unlimited right of recoupment.

The dissenting judge below brought this remand issue to the attention of the District Court, as appellants note in their Jurisdictional Statements. A factual

Act No. 94. Ultimately an exchange of letters reaffirmed the fact that there was no fixed upper limit on the amount of "final" reimbursement (A.124-25 ¶¶ 72, 73). Ex. no. 40 (Ex. 441a-444a). At August 2, 1975 there was no fixed limit on the amount of reimbursement, interim or final, to which a DVHC hospital was entitled under the formula. Appellants in No. 75-1698 concede the point (J.S. at 8).

inquiry into alleged confiscatory effect conceivably could be appropriate if (as the dissenting judge thought) Act No. 94 set a fixed price unresponsive to inflationary pressures. However, as noted earlier, the statute is open-ended and automatically adjusts for inflation, and appellants have expressly conceded that the applicable Blue Cross-hospital contract as last amended provides for "full allowable costs with no ceiling upon a final accounting." J.S. in No. 75-1698 at 8.

The dispute here is analogous to a claim that a regulated industry has a constitutional right to a "fair value" as opposed to an "original cost" rate base. Cf. *Hope Natural Gas Co., supra.* It is the *formula* which is attacked, not a specific per diem rate for a specific hospital applicable during a specific period of time. Thus the request of the appellants for further hearing below or before a state agency is wholly inapposite, since the validity of the formula as an exercise of State legislative policy is a question of law.

VI: THE TERMS OF FINAL SETTLEMENT FOR ADMISSIONS TO THE APPELLANT HOSPITALS FOR THE PERIOD INCLUDED WITHIN THE AUGUST 15, 1974 TO AUGUST 2, 1975 REGULATORY HIATUS WERE NOT "VESTED" BEYOND THE REGULATORY POWER OF THE PENNSYLVANIA LEGISLATURE.

As discussed above, Act No. 94 imposes a 10 month (13 month) ratemaking scheme on appellant hospitals, prospectively beginning with the effective date of the

statute. In addition, Act No. 94 imposes the same ratemaking scheme on the hospital appellants in No. 75-1691 retroactively, for the 11½ month period preceding the statute (that is, for the period from the beginning of the "run-out" under the last preceding contract (August 15, 1974) to the effective date of the statute (August 2, 1975)).

In Part VII we will discuss in detail the considerations which have moved this Court to invalidate State action under the Contract Clause. But for our present purposes it is sufficient to note that the Clause does not stand in the way of State action which is prospective in nature, because the social interest sought to be preserved and advanced is an assurance that engagements entered into will be safe from later State action. The shorthand is to say that when the contract is closed the rights have "vested" and are beyond State power.

The only contract which appellants in No. 75-1691 can point to as allegedly impaired by Act No. 94 is the alleged subscriber-hospital contract for full "charges."[28] The subscriber is not before this Court objecting to Act No. 94, because it fulfilled his or her expectation that he or she would pay only $90 for an admission where the "charges" would be $1350.

[28] Although appellants at one point assert that the Pennsylvania legislature "breathed life into the terminated [Blue Cross-hospital] contract" (Brief in No. 75-1691 at 16), it is clear that there has been no legislative amendment of the termination clause of such contract.

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Moreover, the record clearly shows that the hospitals regarded this subscriber-hospital "contract" as highly provisional at best. Repeatedly and always in the past they have unilaterally and retroactively recharacterized admissions during inter-contract intervals, from subscriber-hospital "contracts" (producing $1350 in income) to Blue Cross-hospital admissions (producing $1080 in income) upon the execution of a succeeding Blue Cross-hospital contract (A.85 ¶ 27, A.86-87 ¶ 32, A.87 ¶34, A.90 ¶ 42). Indeed, both appellees and appellants have all along taken the position that whatever agreement is reached in the current contract negotiations will be made retroactive to the August 15, 1974 commencement of the run-out of the last contract between the parties, thereby substituting parties and changing the basis of payment.[29]

It is well established that regulated businesses may be required to enter into contracts with specified classes of customers. See, *e.g.*, 15 U.S.C. § 717f(a) (Natural Gas Act). Moreover, where a regulatory statute adopts by reference the terms of a private contract, those terms are incorporated into the statute and completely cease being a matter of contract. *Pennsylvania Water & Power Co., supra*, 343 U.S. at 421-22. That is, the General Assembly imposed a statute and not a contract on the hospitals. And it has been well established for more than half a century that private contracts fixing the charges to be collected by regulated businesses, even during their stated term, are regarded as entered into subject to the reserved authority in the State to modify the contract rate in the interest of the public welfare. *Union Dry Goods Co.* v. *Georgia Public Service Corp.*, 248 U.S. 372 (1919). See also Anno. 9 A. L. R. 1423 (1920).

[29] *See* letter from counsel for DVHC (Ex. no. 29). Thus the argument of appellants in No. 75-1691 that the typical Blue Cross sub-

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To return to the earlier hypothetical example, the hospitals were negotiating for a change in the cost formula which might increase the $120.00 per diem allowed cost to perhaps $123.60, but they had no expectation that they would receive precisely their retail charge ($150) or anything close to it. Thus, on August 1, 1974, immediately prior to the signing of Act No. 94, no hospital administrator knew who was going to pay the hospital for Blue Cross subscriber admissions for the prior 11½ months, nor could the administrator reasonably rely on receiving a $150 rate.

As the leading article on the subject suggests, "it has long been recognized that the term 'vested right' is conclusory–a right is vested when it has been so far perfected that it cannot be taken away by statute." C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692, 696 (1960). In the instant case, appellants cannot complain that the Pennsylvania legislature has impaired their "vested rights" to a specified payment level, since appellants themselves have acted to prevent the jelling of the identity of the parties and the rate of payment for Blue Cross subscriber admissions

scriber who renewed his coverage after July 31, 1974 in effect did so without justifiable expectation of coverage in a DVHC-represented hospital is obviously specious. The 2,400,000 members of the general public were entitled to assume, particularly in view of the enormous consequences of a shift to nonmember status, that the dispute would ultimately be settled retroactively—as it had always been before.

during the hiatus period which the statute seeks to correct.[30]

Thus, under recognized traditional principles of constitutional law, the retroactive aspect of Act No. 94 is well within the band of discretion granted State legislatures in economic matters.

VII: UNDER ESTABLISHED PRINCIPLES A STATE MAY EXTEND THE REACH OF ITS 10 MONTH (13 MONTH) TEMPORARY RATE PROCEDURES RETROACTIVELY FOR VARYING PERIODS UP TO 11½ MONTHS TO CLOSE A GAP IN REGULATION AND TO AVOID INVIDIOUS DISCRIMINATION AMONG BLUE CROSS SUBSCRIBERS.

It may be noted that the policy of Act No. 94 in its retroactive aspect (Parts VI and VII of this Brief) differs from the policy of the statute in its prospective (Parts II through V) and future aspects. That is, as to the 13 months following enactment of Act No. 94 and as to disputes under future contract terminations, the Pennsylvania legislature has sought to create a mechanism whereunder subscribers would not forego possibly vital hospital services out of fear of financial hardship. As to the 11½ months preceding enactment of the statute, on the other hand, this policy has no

[30] In *Murphy Nursing Home, supra*, rate action taken on June 25, 1969 and made retroactive to January 1, 1969 was held constitutional because the superseded rates were provisional or tentative rates, citing this Court's decision in *Great Northern Ry.* v. *Sunburst Oil & Ref. Co.*, 287 U.S. 358, 362 (1932).

application; that is, medical services have either been sought or foregone. Rather, the rationale for Act No. 94 in its retroactive element is the superficially inconsistent goals of relief from exorbitance in charges for hospitalization services and the strengthening of the cash-flow positions of the affected hospitals. For the reasons discussed in this Part VII, it is clear that the relief provided by retroactive application of Act No. 94 is constitutionally permissible.

A. Retroactivity is justifiable where it has been used to fill gaps in a regulatory system. *Fleming* v. *Rhodes*, 331 U.S. 100 (1947), involved an extension of the Emergency Price Control Act. After the original statute expired on June 30, 1946, several landlords obtained eviction orders in a State court without the certificates which the statute had required. Since the July 25, 1946 extension of the act had as its effective date June 30, the Price Administrator sought to enjoin the eviction of tenants under the State judgments. The District Court refused to enjoin the evictions, holding that the extension act violated the Constitution by retroactively invading vested rights of the landlords. On direct appeal, this Court reversed, stating: "Federal regulation of future action based upon rights previously acquired by the person regulated is not prohibited by the Constitution . . . The rights acquired by judgment have no different standing." 331 U.S. at 107.

It has been noted that "Although [the Court's] language is overly broad, the result is explainable by the strength of the public interest in not permitting a gap in the regulatory scheme and the fact that the extension of the act was certainly not totally unexpected." Hochman, *supra*, at 719. The same is true in the case at bar. The public interest in preventing gaps in price control schemes is at least as great in respect of health care as housing. And given the ferment in the Pennsylvania legislature for at least six years preceding Act No. 94 (see A.93 ¶ 54), the statutory plugging of the regulatory gap resulting from the failure of contract negotiations between the parties cannot be said to have been totally unexpected.

B. The retroactive feature of the legislation provides a well known reparations remedy. To the extent that Act No. 94 precludes appellant hospitals from collecting their full charges uncollected as of August 2, 1975 (*i.e.*, the effective date of the statute), it is valid under the rule of *Fleming* v. *Rhodes*. In addition, Act No. 94 requires appellant hospitals to disgorge "excess profits" collected prior to August 2, 1975. In this respect as well, the statute is fully justified under settled principles of regulatory law.

At common law, ratepayers had a right to be charged no more than a reasonable rate. Thus, an action for damages would lie where a carrier refused to receive goods offered for carriage except upon the

payment of an unreasonable sum. And an action to recover the excess over a reasonable rate would lie where in the absence of prior agreement as to price a carrier conditioned delivery of goods upon payment of an unreasonable exaction, or even where an exorbitant charge was stated on the receipt of the goods and coercively exacted either in advance or at the completion of the service. *Tex. & Pac. Ry. Co.* v. *Abilene Cotton Oil Co.*, 204 U.S. 426, 436 (1907); *Centre Cty. Lime Co.* v. *Pub. Serv. Com.*, 96 Pa. Super. 590, 602 (1929). Cf. *TIME, Inc.* v. *United States*, 359 U.S. 464, 472 n. 12 (1959) (questioning whether the common law right is to be free from undue discrimination rather than exorbitance).

The later right, to recover the excess over a reasonable rate, is, in ratemaking parlance, a right to "reparations". This right of ratepayers to reparations in respect of excessive company-made rates[31] provides something of a mirror image to the right of the company to recoupment in respect of inadequate agency-made temporary rates.

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[31] Administrative agencies may award reparation to ratepayers in respect of excessive company-made rates. Agency-made rates are not the subject of reparation. In the instant case, rates set unilaterally by the hospitals without reference to the last approved contract or Act No. 94 have the status, obviously, of company-made and not agency-made rates. See *Arizona Grocery Co.* v. *Atchison, T. & S.F. Ry. Co.*, 284 U.S. 370 (1932); *Pennsylvania R.R. Co.* v. *Pub. Serv. Com.*, 190 A.367, 371-72, 125 Pa. Super. 558, 567 (1937).

The common law right of ratepayers to reparations has been codified by both State and Federal statutes providing for reparation awards by administrative agencies. Under the Pennsylvania Public Utility Law, for example, regulated companies may be required to refund to a class of ratepayers any unjust or unreasonable portion of a rate paid within two years prior to a complaint. And under the Interstate Commerce Act, regulated companies may be compelled, by suit brought or complaint filed within two years from the time the cause of action accrues, to reimburse ratepayers in respect of unjust and unreasonable rates. 66 P.S. § 1153; 49 U.S.C. §§ 16(3) (railroads), 304a (motor carriers), 908 (water carriers), 1006a (freight forwarders).

To be sure, the legislative authority may vary or even abrogate the common law right to reparations. Thus, the Pennsylvania legislature, for example, has done away with the common law doctrine that a rate is unreasonable for reparation purposes only if extortionate or oppressive. And the Congress, on the other hand, has wholly abolished reparation rights in respect of rates subject to the Federal Power Act. *Pennsylvania R.R. Co.* v. *Pub. Serv. Com., supra*, 190 A. at 370, 125 Pa. Super. at 563; *Montana-Dakota Utilities Co.* v. *Northwestern Pub. Serv. Co.*, 341 U.S. 246 (1951).

Act No. 94 in its retrospective aspect, then, is a reparation statute. Like all such statutes, it reaches

backward to provide for the retrospective readjustment of rates set by the provider fixing the rates. Thus, it gives effect to the common law right of ratepayers to just and reasonable rates, and provides a remedial mechanism whereby ratepayers may enforce their claim to any excess over a reasonable rate.

Nor does Act No. 94 overreach in its attempt to protect ratepayers. The rates allowed are, as indicated above, not confiscatory. The 11½ month reparation period is not half as long as the time periods allowed by the above-noted Pennsylvania and Federal statutes. Since subscriber contracts were running out seriatim between August 15, 1974 and August 15, 1975, the retrospective effect is graduated and not total. And the retroactive feature is limited to hospitals which have benefited from the Blue Cross arrangement for at least 10 years (*i.e.*, its maximum impact on any hospital is limited to 11½ out of a 133-month or longer period).

Moreover, because of the effect of the run-out extremely discriminatory conditions would exist absent Act No. 94. A Blue Cross subscriber hospitalized in December 1974 whose subscriber contract anniversary was November 15 would pay $1100 for the very same services which the Blue Cross subscriber in the next bed whose subscriber contract anniversary was January 1 would pay only $90. It has long been recognized in this Court that elimination of discriminatory rate practices is a proper function of State police regulation. See, e.g., *Portland Ry. Light & Power*

Co. v. *Railroad Comm'n of Oregon*, 229 U.S. 397 (1913), and here the degree of discrimination was plainly invidious.

C. Nor does the regulatory scheme violate traditional, non-ratemaking principles of law. Even if the rate regulation cases are put to one side, the health delivery emergency triggered by the refusal of the DVHC hospitals to contract with Blue Cross clearly justified legislative intervention.

In this respect the relief afforded by Act No. 94 was to remove the impediment to the survival of the DVHC hospitals. Appellants' own evidence convincingly suggests that the hospitals live in a precarious cash flow situation (A.112-118). The Blue Cross-hospital contract recognized this fact with its provision for cash flow advances (Ex. No. 20, Ex. 276a-278a). The Pennsylvania legislature could properly take note of the fact that a population which had expected to pay $90 on a hospital discharge might not be in a position to pay $1350; that if even a substantial fraction of the Blue Cross subscriber patients discharged from DVHC hospitals during the run-out period could not or would not pay their bills the financial structure of the health delivery system in southeastern Pennsylvania would be significantly impaired;[32] and that retroactive rein-

[32] The legislature could surely take note of the fact that the hospitals were publicly claiming that without a 3% to 4% "plus factor" on Blue Cross business they would be in the most serious financial

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statement of the Blue Cross-DVHC contract would substitute a massive Blue Cross cash infusion into the hospitals for claims of uncertain collectability against a widely scattered group of patients.

Indeed, the record shows that within days after the enactment of Act No. 94, Blue Cross began to disburse large payments to the hospitals with respect to hiatus-period cases which retroactively became member hospitals admissions by virtue of the Act (A.55-59), thereby assuring the financial stability of the hospitals.

The leading case on the Contract Clause is *Home Bldg. & L. Assn.* v. *Blaisdell*, 290 U.S. 398 (1934). Indeed, in its most recent Contract Clause decision as of this writing[33], this Court recognized that *Blaisdell* amounts to "a comprehensive restatement of the prin-

difficulty; that during the 11½ month run-out approximately 50% of the Blue Cross-subscriber admissions were switched to a "self-pay" basis; that if even one-tenth of these were unable to pay their unexpectedly high hospital bills, approximately 5% of the hospitals' Blue Cross subscriber revenues would be cut off; and conclude that emergency relief was in order. Indeed, although the DVHC hospitals suggest in this Court (Brief in No. 75-1691 at 16) that Act No. 94 deprived them of a veritable bonanza in direct payments by Blue Cross subscribers, there is no record support for the proposition that the many claims against patients were generally collectible, and in point of fact the hospitals during the run-out period unsuccessfully brought suit against Blue Cross to break the non-assignment clause (Article VI, section 3; Ex. 91a-92a) of the Blue Cross-subscriber agreement in an attempt to shore up their cash flow. *Riddle Memorial Hospital et al.* v. *Blue Cross of Greater Philadelphia*, No. 75-1667 (Ct. Com. Pl. of Del. Cty., Pa.).

[33] Cf. *United States Trust Co. of New York* v. *New Jersey*, 134 N.J. Super. 124, 338 A.2d 833 (1975), *aff'd*, 69 N.J. 253, 353 A.2d 514 (1976), *prob. jur. noted*, 44 U.S.L.W. 3748 (1976).

ciples underlying the application of the Contract Clause." *El Paso* v. *Simmons*, 379 U.S. 497,508 (1965).

This Court began its analysis in *Blaisdell* by rejecting a literal approach to the Contract Clause. Not every impairment, it was held, is an impairment in the constitutional sense; literalism, Mr. Chief Justice Hughes stated, "would be better adapted to special pleadings" than to the construing of a Constitution. 290 U.S. at 428 (quoting *Ogden* v. *Saunders*, 12 Wheat. 213, 286). It is "beyond question", the Court held, "that the prohibition is not an absolute one and is not to be read with literal exactness like a mathematical formula." 290 U.S. at 428.[34] Rather, the true test under the Contract Clause is "whether the legislation is addressed to a legitimate end and the measures taken are reasonable and appropriate to that end." *Id.* at 438.

While emergency conditions do not create power, this Court stated, they may furnish the occasion for an exercise of power. And the declarations of emergency in respect of the law "cannot be regarded as a subterfuge or as lacking in adequate basis." *Id.* at 444. To meet these emergency conditions, there is a "necessary resid-

[34] The *Winnebago* case cited by the dissenting judge below misconceives the Contract Clause test and must accordingly be disregarded. Without ever citing a decision of this Court, *Winnebago* reaffirmed the theory of a South Carolina Supreme Court case that "any deviation from the terms of a contract [resulting from subsequent legislation] . . . (i)s an impairing of the obligation of the contract, however minute or apparently immaterial in effect." *Superior Motors, Inc.* v. *Winnebago Inds., Inc.*, 359 F. Supp. 773, 777-78 (D.S.C. 1973).

uum of state power"; "the State . . . continues to possess authority to safeguard the vital interests of its people . . . Not only are existing laws read into contracts in order to fix obligations as between the parties, but the reservation of essential attributes of soverign power is also read into contracts as a postulate of the legal order." *Id.* at 334, 335. That is, "the reservation of the reasonable exercise of the protective power of the State is read into all contracts," and such reserved power may be exercised to meet emergency conditions resulting from economic distress. *Id.* at 444.

If such an emergency makes legislation appropriate, the legislation must also be reasonable in its terms in light of the conditions prevailing.[35] That this Court

[35] Act No. 95 is clearly a reasonable measure since it is limited in time (*i.e.*, to 11½ months), coverage (*i.e.*, to hospitals having benefited substantially continuously for at least 10 years from the system of guaranteed payments policed by the Commonwealth), extent (*i.e.*, most costs are reimbursed, with only free care and other disputed items omitted in reliance on the American Hospital Association-based Medicare formula), effect (any settlement reached by the parties is made effective as of August 15, 1974), and scope (most disputed claims having been settled by accord and satisfaction) (see A.49-65). Thus, the *Kavanaugh* and *Radford* cases cited by appellants are inapposite.

The statute in *Kavanaugh* "cut down the security of a mortgage without moderation or reason [and] in a spirit of oppression". In enacting the statute, the Arkansas legislature "put restraint aside [and acted] with studied indifference to the interests of the mortgagee." Limitations as to "reasonable time" and "compliance . . . with reasonable conditions" were wholly lacking from the statute. *W. B. Worthen Co.* v. *Kavanaugh*, 295 U.S. 56, 60, 61 (1935). *Radford* similarly involved a statute which unreasonably promoted

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might strike a different balance is, of course, beside the point so long as the legislature has not been arbitrary: "Whether the legislation is wise or unwise as a matter of policy is a question with which we are not concerned." *Id.* at 447-48. That is, as this Court reaffirmed in *El Paso*, "The State has the 'soverign right . . . to protect the . . . general welfare of the people . . . Once we are in this domain of the reserve power of a State we must respect the wide discretion on the part of the legislature in determining what is and what is not necessary.'" 379 U.S. at 508-09 (quoting *East New York Savings Bank* v. *Hahn*, 326 U.S. 230, 232-33). In the instant case, the judgment to prefer the immediate and certain cash flow of the reinstated Blue Cross funding for the hope of collections from an unprepared citizenry was peculiarly a legislative determination.

Under the *Blaisdell* legitimate end-appropriate and reasonable means test, it is clear that Act No. 94 is constitutionally permissible.[36] With the financial via-

the interests of mortgagors at the expense of mortgagees. *Louisville Joint Stock Land Bank* v. *Radford*, 295 U.S. 555 (1935) (invalidating the first Frazier-Lemke Act). Compare *Wright* v. *Vinton Branch of the Mountain Trust Bank*, 300 U.S. 440 (1937) (sustaining the revised Frazier-Lemke Act). See also *W. B. Worthen Co.* v. *Thomas*, 292 U.S. 426, 434 (1934) (invalidating an Arkansas statute that "contains no limitations as to time, amount, circumstances, or need").

[36] Appellants variously assert other Contract Clause tests which depart radically from the existing standard. Thus, appellants would strike down Act No. 94 as impairing contractual substance as con-

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bility in the balance of hospitals representing approximately one-half of the nonprofit charitable beds served by Blue Cross of Greater Philadelphia[37], the statute was clearly "addressed to a legitimate end, that is, the legislation was not for the mere advantage of particular individuals but for the protection of a basic interest of society." *Blaisdell*, *supra*, 290 U.S. at 445.

D. Indeed, the Act No. 94 approach is appropriate precisely because it avoids impairing the obligation of Blue Cross-subscriber contracts.

Under the Blue Cross-subscriber contracts, Blue Cross obligates itself to pay allowable costs to hospitals in respect of subscriber admissions to member hospitals, but only the much lower indemnity payments to subscribers in respect of subscriber admissions to nonmember hospitals. Thus, in the absence of Act No. 94,

trasted with remedy (Brief in No. 75-1691 at 23); yet it is clear that "the right-remedy dichotomy is conclusory only, and therefore of little use in deciding a particular case." Hochman, *supra*, at 711-12n. 106. Accord, *Wright* v. *Vinton Branch*, *supra*, 300 U.S. at 470 (Brandeis, J.). Similarly, appellants suggest that legislation may sensibly be assessed without regard to "how great the public need may be", and that the sole test is "the degree of deprivation involved." Brief in No. 75-1691 at 19, 23.

[37] The hospitals on behalf of which the DVHC negotiates have split into two groups. The hospitals represented by the DVHC in this litigation represent in the aggregate approximately one-half of the nonprofit charitable beds served by appellee Blue Cross of Greater Philadelphia. The remaining beds are represented by the seven local medical school hospitals and certain other hospitals which, although represented by DVHC in negotiations, voluntarily settled their dispute with Blue Cross (A.89-90 ¶¶ 40-42).

Blue Cross would only have been obligated to pay the generally lower indemnity benefits for DVHC hospital admissions of ill subscribers. Accordingly, healthy subscribers would have received a windfall, since the reserves of the Plan would have swelled in an amount equal to the excess of the cost of service benefits over the cost indemnity benefits (*i.e.*, $990 service benefit — $250 indemnity benefit = $740 per case reserve augmentation).

Had the General Assembly simply "unlocked" the reserves of the Plan (for example, by enacting that indemnity benefits during the hiatus period should be $150 a day but not more than the hospitals' retail "charges") to provide a needed cash infusion to the DVHC hospitals, healthy subscribers could well have alleged an impairment of their contractual right to have Blue Cross reserves used only to make the payments described in their subscriber contracts, where they would be accompanied by the significant cost controls described earlier. By "reinstating" the Blue Cross-hospital contracts with appellants in No. 75-1691, on the other hand, Act No. 94 allows service benefits to be paid to appellant hospitals in accordance with the terms of the separate Blue Cross-subscriber contracts.

Indeed, if there is any possible defect in the "reinstatement" characterization utilized in Act No. 94, it is the healthy Blue Cross subscribers and not the hospitals who are thereby aggrieved, and those subscribers are not before this Court.

CONCLUSION

For the reasons discussed above, the judgment of the District Court should be affirmed.

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ANNEX A

Part 1: History of Hospital Regulation In Pennsylvania

Originally hospitals were created in Pennsylvania by special act. Thus the act of May 11, 1751, 5 Pa. Stat. 128, 1 Sm. L. 208, which created the Pennsylvania Hospital, expressly declared providing hospitalization to be a "work of public service." The "laws, rules and orders" of the Hospital were made expressly subject to regulation by the Chief Justice, the Speaker of the Assembly and the Attorney General. § 1.

An appropriation of public funds was made to the hospital (§ 2), and its books and records were made subject to audit by visitors appointed by the General Assembly (§ 4). This hospital was thereafter regulated by a succession of detailed acts. *See, e.g.*, act of April 11, 1793, 3 Sm. L. 117.

Hospitals could be and were incorporated under the Corporation Act of 1791, act of April 6, 1791, 3 Sm. L. 20, 14 Pa. Stat. 50, which was a general statute for the incorporation of charitable corporations. Hospital incorporations under this act were scrutinized by the Attorney General and the Supreme Court. Ultimately, by the act of October 13, 1840 (1841 P.L. 1), the reviewing function passed to the courts of common pleas.

By the act of July 17, 1917 (P.L. 1120), any charter application or amendment submitted by any hospital "in which indigent persons are to be treated, or to be treated or maintained, in whole or in part, at public expense" was required to be submitted to the Board of

Public Charities for its opinion as to such matters as whether the needs of the community wherein the hospital was to be located required the incorporation of the hospital.

The act of June 20, 1919 (P.L. 505) (10 P.S. §§ 1-3) requires the approval by the Board of Public Charities (now Department of Public Welfare) of the plans of any private hospital or other private charitable institution as a prerequisite for eligibility for State aid.

The Nonprofit Corporation Law of 1933, act of May 5, 1933 (P.L. 289), §§ 212, 707 and 807 made a favorable finding by the Department of Welfare a prerequisite to incorporation and actions of certain hospitals. These provisions now appear in 67 Pa.C.S.A. §§ 6102 and 6103.

The Pennsylvania Hospital Survey and Construction Act, act of July 5, 1947 (P.L. 1335), provided for a review function and state planning of hospital construction, including the setting of minimum standards for maintenance and operation. This authority was transferred to The Administrative Code of 1929, act of April 9, 1929 (P.L. 177), § 2305.1 and is now Public Welfare Code, act of June 13, 1967 (P.L. 31, No. 21), § 201(c) (62 P.S. § 201(c)).

Proprietary (*i.e.*, profit-making) hospitals were subjected to licensing by the act of June 12, 1931 (P.L. 510). This act was briefly superseded by the act of February 2, 1966 (1965 P.L. 1881) and the provision is now found in the Public Welfare Code, §§ 1001 et seq. (62 P.S. § 1001 et seq.).

Bills to impose direct economic regulation on hospitals have been pending in the General Assembly at least since 1969 (A.93 ¶ 54).

Part 2: Other State Regulation

Alaska Stat. § 21.87.180, Fla. Stat. § 641.03, Code of Ga. § 56-1711, Idaho Code § 41-3416, Ill. Stat. § 32:555, Iowa Code § 514.8, Code of Md. § 48A:356, L. Mass. §§ 176A:5, 6A:32, Mich. Comp. L. § 550.503, Rev. Stat. of Neb. § 21-1512, N. Dak. Cent. Code § 26-26-09, Ohio Rev. Code § 1739.051, S. Dak. Comp. L. § 58-40-12, Tenn. Code § 56-3014, Tex. Ins. Code § 20.15.

See also Code of Ala. § 28-311, Ariz. Rev. Stat. § 20-830, Ark. Stat. § 66-4908, Calif. Ins. Code § 11510, Colo. Rev. Stat. § 10-16-130, Conn. Gen. Stat. § 33-166, Del. Code § 18-6306, Hawaii Rev. Stat. § 393-1, Ind. Stat. § 27-8-6-1, Kan. Stat. § 40-1806, Ky. Rev. Stat. § 304.32-130, La. Rev. Stat. § 22:659, Maine Rev. Stat. § 24-2316, Minn. Stat. § 62C. 16, Miss. Code § 83-41-123, Rev. Code of Mont. § 15-2304, Mo. Stat. § 354.085, Nev. Rev. Stat. § 695 B. 140, N.H. Rev. Stat. § 419:6, N. Mex. Stat. § 58-25-17, Gen. Stat. of N. Car. § 57-4, Okla. Stat. § 36-2606, Ore. Rev. Stat. § 750.005, L. of R.I. §§ 29-19-7, 14, Code of L. of S. Car. § 37-441, Utah Code § 31-37-16, Vt. Stat. § 4513, Code of Va. § 32-195.1, Rev. Code of

Annex A

Wash. § 48.44.070, W. Va. Code § 33-24-6, Wis. Stat. § 182.032, Wyo. Stat. § 26.1-453.1.

See also N.J. Stat. §§ 17:48-7, 26:2H-18, N.Y. Ins. Law § 252, Public Health Law § 2807.

Part 3: Federal Regulation

Hospitals providing Federal Medicare benefits are subject to economic regulation *pro tanto*, and may be reimbursed only for "the reasonable cost of such services." *See generally* 20 C.F.R. § 405.401 et seq.

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